

**APPLICATION FOR CARE AT CORRECTIVE CARE CHIROPRACTIC (CCC)**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Names and Ages of your children: \_\_\_\_\_

Who referred you to our clinic? : \_\_\_\_\_

**HISTORY OF COMPLAINT**

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following: **Your Goals of Wellness Care:**

Please identify, if any complaints, injury or illnesses that brought you to this office:

When did these problem(s) begin? \_\_\_\_\_ is your problem(s) the result of ANY type of accident.

Yes  No

**If yes** identify type:  Auto  Work  Home  Other (please explain): \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Have you suffered with any of this or a similar problem(s) in the past?  No  Yes

If yes, when \_\_\_\_\_

Please state what type of treatment you have tried for this problem(s):

**Who** provided it: \_\_\_\_\_ **When?** \_\_\_\_\_

What were the results?  Favorable  Unfavorable → please explain:

**Are you currently taking any medications? PLEASE LIST:**

\***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms: **R=Radiating B=Burning D=Dull A=Aching S=Sharp/Stabbing T=Tingling N=Numbness**

What percentage of the day do you experience symptoms: \_\_\_\_\_%

What relieves your symptom(s)? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_

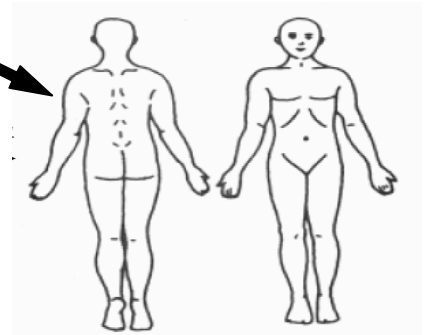
Have you had previous chiropractic care?  Yes  No

Name of previous Chiropractor: \_\_\_\_\_

What were the results? \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain,

Rate how you feel today (**Circle the number**): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



**PAST HISTORY**

If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a:

- Disability  Broken Bone  Fracture  Dislocations  Tumors  Diabetes
- Heart Attack  Rheumatoid Arthritis  Osteo Arthritis  Cerebral Vascular
- Other serious conditions: \_\_\_\_\_

**PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:**

**SOCIAL HISTORY**

- 1. **Smoking:**  cigars  pipe  cigarette → How often?  Daily  Weekends  Occasionally  Never
- 2. **Alcoholic Beverage:** consumption occurs →  Daily  Weekends  Occasionally  Never
- 3. **Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**FAMILY HISTORY:**

- 1. Does anyone in your family suffer with the same condition(s) you currently have?  No  Yes, if yes  
**whom:**  grandmother  grandfather  mother  father  sister(s)  
 brother(s)  son(s)  daughter(s)

Have they ever been treated for their condition?  No  Yes  I don't know

- 2. Any other hereditary conditions the doctor should be aware of.  No  Yes:

I hereby authorize payment to be made directly to Corrective Care Chiropractic for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Corrective Care Chiropractic.

I request the clinic to submit claims to this insurance company: \_\_\_\_\_.

Please provide your insurance card to us for copying. We will determine eligibility.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_  
**Date**

**CONSENT TO TREAT A MINOR**

**MINOR PATIENT'S NAME:** \_\_\_\_\_

The risks associated with exposure to ionization, and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor, and after careful consideration I do hereby request, and authorize Corrective Care Chiropractic to perform imaging studies, and chiropractic adjustments, to my minor child, for whom I have the legal right to select, and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse /former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way I will immediately notify this office.

\_\_\_\_\_  
Parent /Legal Guardian

\_\_\_\_\_  
Date