APPLICATION FOR TREATMENT
Dr. John K. Whitham
Chiropractic Physician

File#_____

Date:_____

PERSONAL INFORMATION

Name _____ Age _____Birthdate ____/____/_____
First M.I. Last

Address_____ City _____ State____ ZIP_____

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail_____

Social Sec. Number _____-_____-_____ Single____ Married____ Widowed____ Divorced____ Separated____

EMPLOYMENT & INSURANCE

Employer _____ Your Occupation_____

Employer Address_____ City _____ State____ ZIP_____

Insurance Carrier_____ Group/Plan Number_____ Contact Phone_____-_____-_____

Insurance Address_____ City _____ State____ ZIP_____

Who is responsible for your bill: Self____ Spouse____ Employer____ Insurance____ Other____

Type of Insurance: Group Insurance ____ Blue Cross/B.S.____ Medicare____ Worker's Comp____ Auto Policy____ (Check One)

Method of Payment: Cash____ Check____ Credit Card____ Auto Ins. Policy____ Health Ins. Policy___ Other____

FAMILY HISTORY

Name of Spouse_____ Ages of Children_____

Spouse's Employer_____ Business Phone _____

Nearest Relative _____ Relative's Address _____

Relative's Phone Number_____ Referred to our office by:_____

CURRENT HISTORY

Please describe the Primary Health challenges for which you came to this office:_____

_____

_____

How and When did symptoms first occur?:_____

List any other doctors seen by you for these problems:_____

List Diagnosis(es) and Type of Treatment(s):_____

_____

Does this interfere with your normal living and work? Yes____ No____ In what way? _____

Have you lost any days of work? Yes____ No____ What dates? _____

Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain _____

_____

List relationship of any relatives who have or have had a similar problem:_____

_____

File #_____ Patient Last Name_____

PAST HISTORY

Have you been treated for any health condition by a physician in the last year? Yes____ No____ If yes, explain:_____

_____

Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain_____

_____

List approximate type ad dates of any operations, diseases, serious illnesses or accidents you have had (including broken bones)

_____

_____

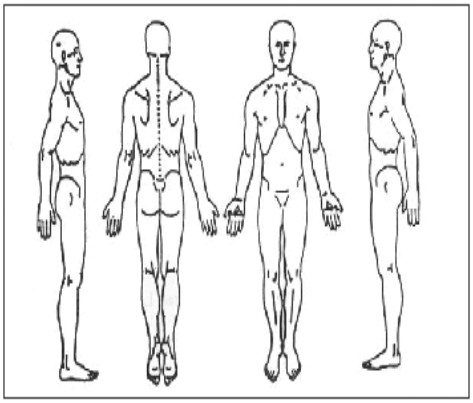
List all drugs or medications you used recently (i.e., aspirin, sleeping pills, birth control, blood pressure, etc.)_____

_____

_____

TREATMENT

Please mark your areas of pain on the figure below.



List the health challenges you are most interested in improving.

List in order of importance to you.

1._____

2._____

3._____

4._____

What functions are you unable to perform or which induce pain upon performance?

List in order of severity. (i.e., sitting, standing, walking, bending, lying down, etc.)

1._____

2.._____

3._____

4._____

I UNDERSTAND AND AGREE ALL FEES ARE PAYABLE IN FULL AT THE TIME EXAMINATIONS, TREATMENTS, AND X-RAYS ARE RENDERED ON MY BEHALF, REGARDLESS OF INSURANCE COVERAGE, UNLESS OTHER ARRANGEMENTS ARE MADE EXPRESSLY IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THE CLINIC AT ALL TIMES. I HEREBY APPLY FOR TREATMENT AND GIVE MY PERMISSION FOR TREATMENT.

_____ _____

Signature of Patient Signature of Responsible Party

Dated: _____ Dated: _____