APPLICATION FOR TREATMENT

Dr. John K. Whitham, D.C. | Dr. Ashley Norman, N.D.

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 _____

Referred to our office by:_____

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: None: _____ Group Insurance: _____ Blue Cross/B.S._____ Medicare_____ Auto Policy_____

Method of Payment: Cash_____ Check_____ Credit Card_____ Auto Ins. Policy_____ Other_____

NOTE: Services provided by licensed Naturopathic Doctors are not eligible for insurance submission or reimbursement in Oklahoma.

FAMILY HISTORY

Name of Spouse_____ Ages of Children_____

Do you or anyone in your household work with chemicals known to be toxic or harmful? No: _____ Yes: _____ Please explain: _____

_____

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 (health care providers) you have seen 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 or school? Yes____ No____

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

_____

Have any relatives had a similar problem? Please, explain: _____

PAST HISTORY

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

_____

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

_____

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

_____

_____

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

_____

_____

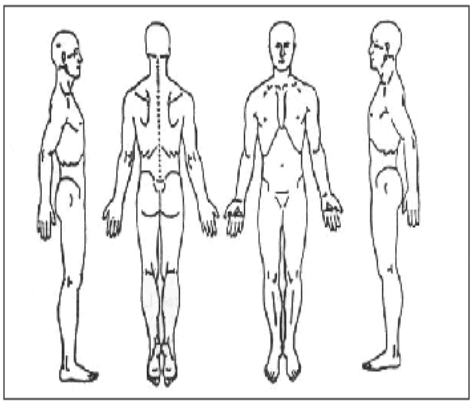
List all supplements you have used recently: _____

_____

TREATMENT

List the health challenges you are most interested in addressing.

Please mark your areas of pain on the figure below.



1._____

2._____

3._____

4._____

5._____

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

Date: _____ Date: _____