

Boyden Family Chiropractic – Application For Treatment

Name (first) _____ (middle) _____ (last) _____
Address _____
City _____ State _____ Zip _____
Home Phone () _____ Office Phone () _____
Date of Birth _____ Referred to our office by _____
Social Security Number _____ Number of Children _____

Please check or circle: Married Single Widowed Divorced Separated

Please select: Male Female Are you currently pregnant? Yes No

What type of care do you desire: Temporary Relief Lasting Correction Best Care Possible

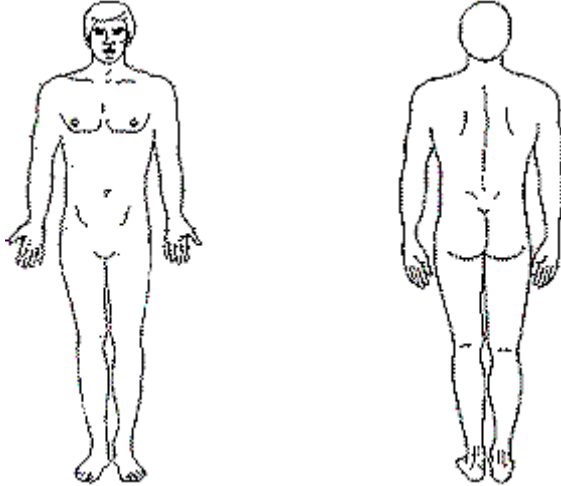
Email Address _____

Where are you employed? _____
Address _____
City _____ State _____ Zip _____

How will payment be made? (Please indicate)
 Health Insurance Worker's Comp. Auto Insurance Cash Check Credit Card

Major complaint ('s) Please describe your major complaint's and describe the frequency and nature of your pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.

Please mark the exact location of your pain or symptoms on the diagrams below.



When did your condition first begin? _____

How did your condition develop? _____

What caused it? _____

Have you ever had this problem or similar problem before? _____ If yes, please explain: _____

Have you seen another chiropractic physician for this complaint? If yes, who? _____

What was their diagnosis? _____

Have you seen another medical physician for this complaint? If yes, who? _____

What was their diagnosis? _____

Is your condition getting better, worse, or staying the same? _____

What makes your conditions worse? _____

What makes your conditions better? _____

Have you ever been involved in an automobile accident? _____ If yes, when and where? _____

What surgeries have you had? Include Date: _____

Please list drugs you now take: _____

Please list vitamins, minerals, supplements, and/or herbs you now take: _____

Please check if you have a history of the following:

Arthritis _____ Depression _____ Kidney Condition _____ Cancer _____

Epilepsy _____ Tuberculosis _____ Heart Condition _____ Scoliosis _____

Diabetes _____ Nervousness _____ Liver Condition _____ Headaches _____

High Blood Pressure _____ Sinus Condition _____ Stomach or Gastrointestinal Condition _____

Other Conditions or additional comments: _____

CONFIDENTIAL INSURANCE INFORMATION

Insurance Information: Name of Insured: _____

Insurance Company (primary) _____

Address _____ City _____ State _____ Zip _____

Telephone () _____

Policy group or Certification Number _____

List any Secondary Insurance _____

Spouse's Information:

Name _____

Address _____ (City, State, and Zip) _____

Work Number () _____ Home Number () _____

Employer _____

Address _____ (City, state, and Zip) _____

Date of Birth _____

Signature _____ **Date** _____