Print Form

HUDSON FAMILY CHIROPRACTIC AND PHYSICAL THERAPY

APPLICATION FOR TREATMENT

CONFIDENTIAL PATIENT INFORMATION

Who referred you to our office?

Is your visit due to an accident? ○ Yes ○ No

(If yes, please complete separate form in office)

PATIENT DATA

Name | Home Phone

Address | Cell Phone

City | Work Phone

State Zip | Birthdate Age

Occupation | Marital Status

Employed By | Business Address

Emergency Contact | Phone

Email Address

PRIMARY CARE PHYSICIAN

Name | Phone

City | State

PRESENT COMPLAINT

Describe your reason for coming to our office today

Since the time of this (these) complaint(s) began, what, if anything, have you tried that did not work?

Has the problem interrupted your sleep? ○ Yes ○ No

If yes, how?

Have you seen any other doctors for this problem? ○ Yes ○ No

Doctor's Name

Were you hospitalized? ○ Yes ○ No

If yes, how many days; what hospital; and how many work days did you miss?

Have you been to a chiropractor before? ○ Yes ○ No

If yes, date of your last visit

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HUDSON FAMILY CHIROPRACTIC AND PHYSICAL THERAPY

MEDICAL HISTORY

☐ Generalized Pain	☐ Diabetes	☐ Rheumatism	☐ Tremors	☐ Muscle Spasm
☐ Concussion	☐ Anemia	☐ Asthma	☐ Arthritis	☐ Heart Trouble
☐ Convulsions	☐ Cancer	☐ Nose Bleeds	☐ Dizziness	☐ Epilepsy
☐ Numbness	☐ Neuritis	☐ Faintness	☐ Joint Pain	☐ Joint Swelling
☐ Backaches	☐ Headaches	☐ Sinus Trouble	☐ High Blood Pressure	
☐ Bleeding Disorder	☐ Benign Bone Tumor	☐ Osteoporosis	☐ Anticoagulant Therapy	

☐ Other _____

PREVIOUS CARE

Surgeries _____ When? _____

Have you been treated by a doctor in the last 12 months? _____

Describe Condition _____

Date of last physical exam _____

Are you pregnant? _____ Due Date? _____

INSURANCE INFORMATION

Name Of Insurance Carrier _____

Member\Subscriber Id Number _____

Provider Services Phone Number _____

PATIENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued reminisces for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Spouse or Guardian Signature: _____ Date _____

If your injury is the result of an accident please complete a separate accident form.