WINCHELL
CHIROPRACTIC & WELLNESS CENTER

Treatment Application

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Preferred Phone_____ Email_____

Age_____ Birth Date_____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Employer_____ Occupation_____

Work Address_____ Work Phone_____

Spouse Name_____ Occupation_____

Spouse Employer_____ Work Phone_____

Nearest Relative_____ Phone_____

Relative's Address_____

Who is responsible for your bill? ☐ Self ☐ Insurance ☐ Parent ☐ Other_____

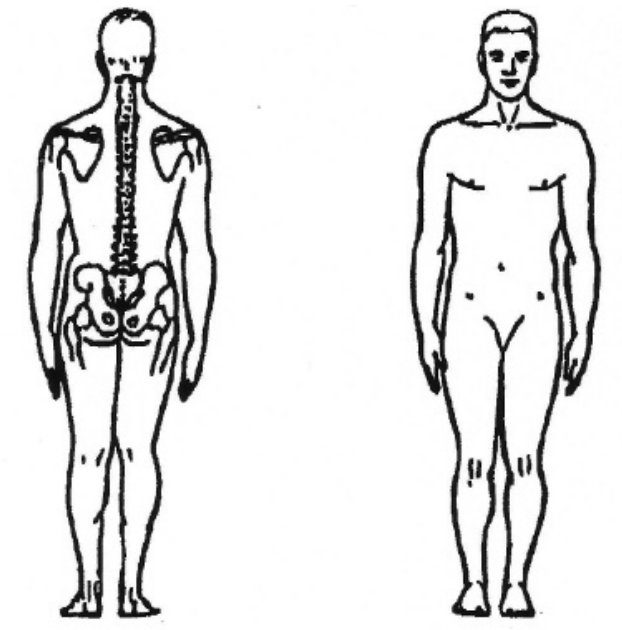
How did you hear about us? _____ Who may we thank for referring us?_____

How did the condition you are seeking care for develop? Cause?_____

_____

When were you first aware of this condition?_____

If You Have Pain, Mark Location Below



Check Current Major Symptoms

☐ Headache	☐ Neuropathy	☐ Fever
☐ Neck Pain / Whiplash	☐ Pins & Needles Feet	☐ Sinus Congestion
☐ Shoulder Pain	☐ Pins & Needles Hands	☐ Sore Throat
☐ Elbow Pain	☐ Numbness in Feet	☐ Coughing
☐ Wrist or Hand Pain	☐ Numbness in Hands	☐ Ear Infections
☐ Back Pain	☐ Cold Feet	☐ Gastric Reflux
☐ Disc Injury	☐ Cold Hands	☐ Upset Stomach
☐ Sciatica	☐ Dizziness	☐ Tension-Stress
☐ Hip Pain	☐ Loss of Balance	☐ Loss of Memory
☐ Knee Pain	☐ Fainting Spells	☐ Nervousness
☐ Ankle-Foot Pain	☐ Chest Pain	☐ Other

Check If You Have Any History

☐ Heart trouble	☐ Tuberculosis	☐ Arthritis
☐ Diabetes	☐ Liver trouble	☐ Asthma
☐ Cancer	☐ Anemia	☐ Other
☐ Rheumatic Fever	☐ Stomach ulcers	☐ Other

Have you ever had the same or similar condition before? If yes, please explain:_____

_____

Have you ever received treatment for this condition? ☐ Yes ☐ No If yes, where and when:_____

_____ What were your results?_____

This condition has been getting: ☐ Better ☐ Worse ☐ Staying the same

Is there anything specific that makes your condition worse?_____

How has this condition affected your HOME LIFE?_____

How has this condition affected your OCCUPATION?_____

How has this condition affected your RECREATION?_____

How has this condition affected your REST AND SLEEP?_____

Have you ever been in an automobile collision? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

Past surgeries:_____

Medications currently taking:_____

Have you consulted any chiropractor in the past? ☐ Yes ☐ No If yes, when?_____

Name and location_____ Results_____

Fees due at time of service, unless other arrangements are made in advance. X-rays remain property of the clinic.

Responsible Party's Signature_____ Date_____

IF THIS IS AN AUTO ACCIDENT OR JOB RELATE INJURY, PLEASE COMPLETE THE FOLLOWING

Accident Date_____ Time_____ Location_____

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other_____

If not an auto collision, please describe the circumstances_____

If this is an on-the-job injury, did you report the injury to your employer? ☐ Yes ☐ No

If this is an auto collision injury:

Where you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked
Did your car strike the other auto(s)? ☐ Yes ☐ No ☐ Undetermined
Did an auto strike yours? ☐ Yes ☐ No ☐ Undetermined

List injuries/damages as you know them:_____

Did you require hospitalization? ☐ Yes ☐ No Have you lost days of work? ☐ Yes ☐ No Dates_____