PLEASE CHECK THE CARE DESIRED: [ ] TEMPORARY RELIEF [ ] LASTING CORRECTION

[ ] **Please check here if you want the Doctor to recommend the best type of care for you**

DATE:________________ INSURANCE ID#________________________________

NAME______________________________ DATE OF BIRTH________________

ADDRESS______________________________ CITY________________

STATE__________ ZIP______________ HOME PHONE________________________

PLACE OF BUSINESS____________________ BUSINESS PHONE____________________

WHAT DO YOU DO?______________________ HOURS/DAYS/WEEK?______________

YOUR DAYS OFF______________ REFERRED TO OUR OFFICE BY:________________

CHECK IF YOU ARE: [ ] MARRIED [ ] SINGLE [ ] WIDOWED [ ] DIVORCED [ ] SEPARATED

NAME OF HUSBAND/ WIFE____________________ AGES OF CHILDREN______________

WHERE IS HUSBAND/ WIFE EMPLOYED?________________________________

WHO IS RESPONSIBLE FOR YOUR BILL? [ ] SELF [ ] SPOUSE [ ] INSURANCE [ ] OTHER

HOW PAYMENT WILL BE MADE? [ ] CASH [ ] CHECK **NOTE: We cannot accept Credit Cards**

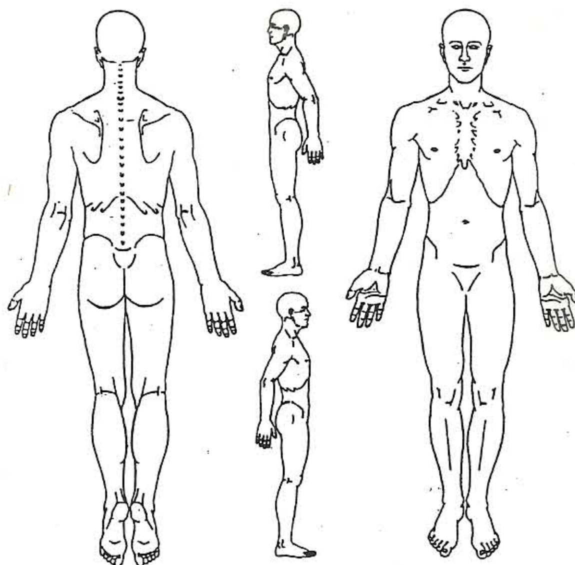
TYPE OF INSURANCE: [ ] WORKER'S COMP [ ] HEALTH INSURANCE [ ] AUTO INS POLICY

YOUR CHIEF COMPLAINT(S)____

____

____

On the illustration below, please mark the exact location(s) of your pain or injury.



Describe Your Pain

Sharp
Dull
Aching
Burning
Throbbing
Shooting
Electric shock
Tingling
Numbness
Constant
Comes and goes