DUGGAN CHIROPRACTIC

APPLICATION FOR TREATMENT

Date:_____

Name:_____ Nickname:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: _____ Ages of Children:_____

Where are you or your husband/wife employed?_____

Your days off:_____ Referred to our office by:_____

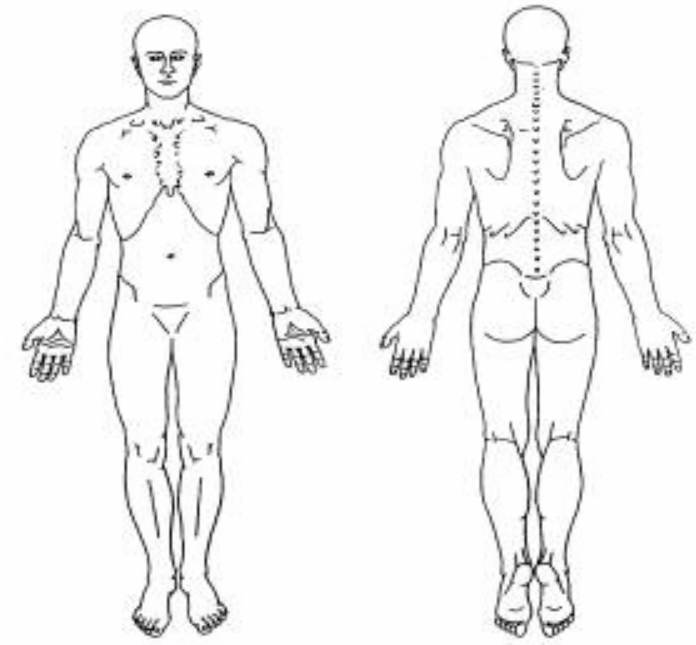
Who is responsible for your bill: ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other_____

How payment will be made: ☐ Cash ☐ Check ☐ Credit Card ☐ Workers' Comp.
☐ Auto Insurance Policy ☐ Health Insurance

Name of Company and Address:_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing

A= Ache **B**=Burning **N**= Numbness
O= Other **P**= Pins & Needles **S**= Stabbing



Major Complaint
(Please describe only your major complaint)

How did this condition develop? (What caused it? How did it start?)_____

When was the very first time you were aware of this problem? ☐ Immediately ☐ Within Hours ☐ Within Days
☐ Other, explain: _____

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

Have you received any treatment for this condition? If yes when, where and what were your results?_____

Has this problem been getting better, worse or staying the same? _____

Is there anything you do that makes your condition worse? (Example: sitting, standing, bending, etc) _____

Is there anything that makes it better? (Example: medication, heat, ice, rest, etc) _____

How has your condition affected the activities of your daily life? (What has it stopped you from doing?) _____

When was your last physical exam? _____

When is the last time you had x-rays taken? Where? (Dates) _____

Is there any chance you could be pregnant? ☐ Yes ☐ No

Have you ever been in an automobile accident? If yes, briefly explain injuries and gives dates: _____

Have you ever had surgery? If yes, briefly explain and gives dates: _____

Have you broken/fractured bones? If yes, briefly explain and gives dates: _____

Have you ever had any sprains/strains? If yes, briefly explain and gives dates: _____

Have you ever been hospitalized? If yes, briefly explain and gives dates: _____

Have you ever experienced any head injuries or been knocked unconscious? If yes, briefly explain and gives dates:

What medications or dietary supplements do you take? _____

Do you have any family history of illness? (Example: Arthritis, back problems, cancer, diabetes, heart disease, high blood pressure, other…) _____

Categorize the following habits in terms of none, light, moderate or heavy:

Habit	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Quadruple Visual Analogue Scale

PLEASE READ CAREFULLY

Instructions: Please circle the number that best describes the question being asked based on your complaint.

Note: If you have more than one complaint, please answer each question with the pain score that coordinates with each individual complaint

Example:

Headache Neck Low Back

No Pain _____ Worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

1– What is your pain RIGHT NOW?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2– What is you TYPICAL or AVERAGE pain?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3– What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4– What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Have You Ever Suffered From: (Circle all that Apply)

Alcoholism	Digestion Problems	Loss of Balance	Swelling of Ankles
Allergies	Dizziness	Loss of Smell	Swollen Joints
Anemia	Ears Ring	Loss of Taste	Thyroid Condition
Arteriosclerosis	Excessive Menstruation	Neck Pain/Stiffness	Tuberculosis
Arthritis	Eye Pain/Difficulties	Nervousness	Ulcers
Asthma	Fatigue	Nosebleeds	Varicose Veins
Back pain	Frequent Urination	Pacemaker	Venereal Disease
Breast Lump	Headache	Polio	Other:
Bronchitis	Hemorrhoids	Poor Posture	
Bruise Easily	High Blood Pressure	Prostate Trouble	
Cancer	Hot Flashes	Sciatica	
Chest Pain/Conditions	Irregular Heart Beat	Shortness of Breath	
Cold Extremities	Irregular Cycle	Sinus Infection	
Constipation	Kidney Infection	Sleep Problems/Insomnia	
Cramps	Kidney Stones	Spinal Curvatures	
Depression	Loss of Memory	Stroke	

Have consulted any Chiropractors in the past? Name:_____
Dates consulted:_____ For what problem?_____

Fees are payable at the time of x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain property of this clinic.

Patient's Signature:_____ Social Security No.:_____ Date:_____
Emergency Contact: _____ Phone Number:_____

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

I hereby authorize and direct you, my insurance company, and/or my attorney , to pay directly to Duggan Chiropractic such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits , medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment of verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of this Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim of action as they see fit.

I understand that I remain personally responsible for the total amount due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize other Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including but not limited to all court cases and all attorney fees.

Patient: _____ Date:_____

Witness:_____ Date:_____