grothman clinic
ADVANCED CHIROPRACTIC SOLUTIONS

APPLICATION FOR TREATMENT

Please check the type of care desired: ❑ Temporary Relief ❑ Lasting Correction

❑ Check here if you want the Doctor to select the type of care he feels is best for you. Date: ____________________

Name: ____________________ Date of Birth: ____________________

Address: ____________________ City ____________________ State ______ Zip Code ____________

Home Phone Number: ____________________ Work Phone Number: ____________________

Cell Phone Number: ____________________ Email: ____________________

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

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

Employer: ____________________ Hours: ____________________

Days off: ____________________ Referred to our office by: ____________________

Who is responsible for your bill? ❑ Self ❑ Spouse ❑ Employer ❑ Insurance ❑ Other ____________

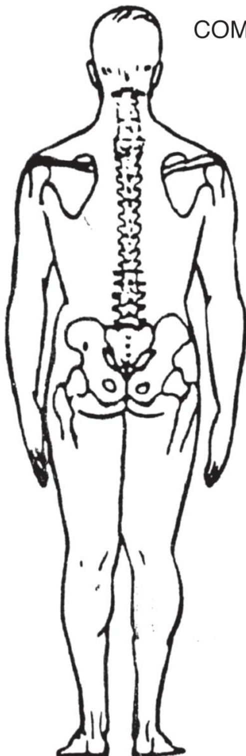
How Payment will be made: ❑ Cash ❑ Check ❑ Credit Card

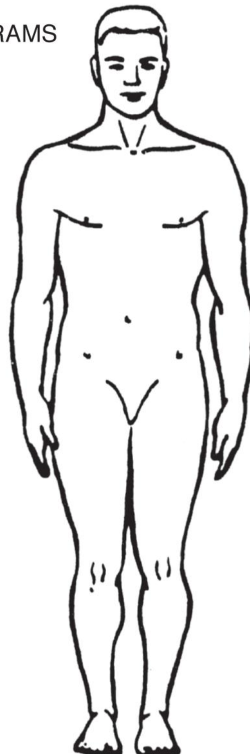
Type of Insurance: ❑ Health Insurance ❑ Automobile Ins. Policy ❑ Workmen's Comp.

Name of Insurance Company: ____________________

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS





MAJOR COMPLAINT
(Please describe only your major problem)

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(PLEASE COMPLETE REVERSE SIDE)

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

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When was the very first time you were aware of this problem? ____________________

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

____

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

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

____

Is there anything you do that makes your condition worse? ____________________

____

How has this condition affected your life?

A. Home life ____________________

B. Occupational life ____________________

C. Recreational life ____________________

D. Rest and Sleep life ____________________

Have you ever been in an automobile accident? ❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never

Any accidents, falls, etc., that might have caused your problem? ____________________

____

Any medical diagnosis of your complaint? ____________________

What surgery has been done? ____________________

____

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers ❑ Muscle Relaxers ❑ "Pep" Pills ❑ Tranquilizers ❑ Insulin

❑ Birth Control Pills ❑ Other (please list) ____________________

Any chiropractor consulted in the past? Name: ____________________

Dates consulted: ____________ For what problem? ____________________

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance.

X-rays remain the property of this clinic.

Patient's Signature: ____________________ Social Security No. ____________________ Date ____________