PATIENT APPLICATION AND CONSULTATION FORM

(PLEASE PRINT)

NAME____CALLED NAME _______________

SOCIAL SECURITY# ______-_____-_______ DOB _____/_____/_______ MALE / FEMALE

ADDRESS ____

CITY ____________________________________ STATE ____________ ZIP ________-_______

HOME PHONE (_____) _______-____________ CELL PHONE (_____) _______-___________

E-MAIL ADDRESS____

STATUS: ___ SINGLE ___MARRIED ___ DIVORCED ___ WIDOWED

EMERGENCY CONTACT/RELATIONSHIP ____________________________ (____) ______-_______

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

WHO IS RESPONSIBLE FOR YOUR BILL? **(CIRCLE ONE)**

SELF SPOUSE EMPLOYER INSURANCE OTHER______________________________

PLEASE INDICATE REASON FOR VISIT ____

PLEASE CHECK TYPE OF CARE DESIRED: __ TEMPORARY RELIEF __ LASTING CORRECTION

PLEASE CIRCLE THE CORRECT RESPONSE

HAVE YOU EVER BEEN DIAGNOSED OR TOLD YOU HAVE ANY OF THE FOLLOWING?

1. HIGH BLOOD PRESSURE? YES/NO
2. HARDENING OF ARTERIES (ATHEROSCLEROSIS)? YES/NO
3. DIABETES? YES/NO
4. HEART OR BLOOD VESSEL DISEASE? YES/NO
5. BONE SPURS IN THE NECK (CERVICAL SPONDYLOSIS)? YES/NO
6. WHIPLASH INJURY? YES NO
7. HAVE YOU OR ANY RELATIVE SUFFERED FROM A STROKE? YES/NO
8. DO YOU TAKE MEDICATION? YES/NO
   LIST: ________________________________
9. DO YOU TAKE NUTRITIONAL VITAMINS OR SUPPLEMENTS? YES/NO
   LIST: ________________________________
10. HAVE YOU EVER HAD SURGERY? YES/NO
   LIST: ________________________________
11. (WOMEN ONLY) HAVE YOU EVER TAKEN ORAL CONTRACEPTIVES? YES/NO
   WHEN? ________________________________

HAVE YOU HAD ANY OF THE FOLLOWING, EVEN SHORT, TEMPORARY ATTACKS IN THE LAST YEAR?

1. BLURRED VISION? YES/NO
2. DOUBLE VISION? YES/NO
3. DIMINISHED OR PARTIAL VISION LOSS? YES/NO
4. COMPLETE VISION LOSS IN ONE OR BOTH EYES? YES/NO
5. RINGING OR BUZZING IN THE EARS? YES/NO
6. HEARING LOSS IN ONE OR BOTH EARS? YES/NO
7. SLURRED SPEECH OR OTHER SPEECH PROBLEMS? YES/NO
8. DIFFICULTY SWALLOWING? YES/NO
9. DIZZINESS? YES/NO
10. TEMPORARY LACK OF UNDERSTANDING? YES/NO
11. LOSS OF CONSCIOUSNESS /BLACKOUTS? YES/NO
12. NUMBNESS OR LOSS OF SENSATION IN THE FACE, HANDS, ARMS, FEET, LEGS, ETC.? YES/NO
13. ANY OTHER ABNORMAL SENSATIONS IN ANY PART OF YOUR BODY? YES/NO
14. WEAKNESS, CLUMSINESS OR LOSS OF STRENGTH? IN THE FACE, FINGERS, HANDS, ARMS, TOES, LEGS, ETC.? YES/NO
15. SUDDEN COLLAPSE W/O LOSS OF CONSCIOUSNESS? YES/NO
16. **ARE YOU INTERSTED IN ENHANCING YOUR NUTRTITION WITH SUPPLEMENTS? YES/NO**

SOCIAL HISTORY

1. ARE YOU CURRENTLY A SMOKER YES/NO
   IF EVER, HOW LONG? ______________________
2. DO YOU CONSUME ALCOHOL? YES/NO
   TYPE/ AMOUNT? ______________________
3. HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? YES/NO
   HOW LONG AGO? ______________________
4. DO YOU CONSUME CAFFEINE REGULARLY? YES/NO
   TYPE/AMOUNT? ______________________
5. DO YOU EXERCISE? YES/NO
   TYPE/ AMOUNT? ______________________
6. HAVE YOU EVER HAD A SEVERE ACCIDENT THAT COULD BE RELATED TO YOUR CONDITION NOW? YES/NO
   HOW LONG AGO? ______________________

Fees are payable at the time treatment or services are rendered, unless other arrangements are made in advance. In the event an account becomes delinquent, the account is subject to collection fees including but not limited to court costs and attorney fees at the cost of the account responsible. X-rays remain property of this clinic and may not be removed from the clinic. Patients may obtain copies of all records and X-rays at an additional charge.

I also, request payment of benefits to be released either to myself or to the party who accepts assignment in my place. I give power of attorney to endorse and or cash checks, drafts, money orders, for chiropractic services and the like, to Dailey Chiropractic Care. I understand that I am personally responsible for charges and/or balances not covered by my insurance.

I have read and agree with the above statement, I give Dailey Chiropractic Care consent for treatment. I authorize the release of any medical records or other information necessary for processing insurance claims. This authorization is to apply to all occasions of service until it is revoked in writing.

X ____ **Date** ________________

(Signature of Patient or Guardian)