

# APPLICATION FOR TREATMENT

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Are you Pregnant:  Yes  No

Employer's Name & Address: \_\_\_\_\_

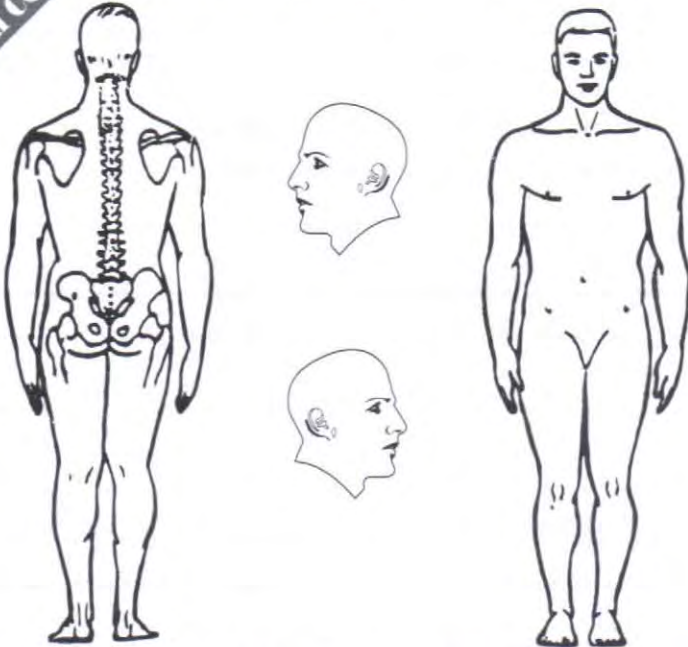
Occupation: \_\_\_\_\_ Work Phone No.: \_\_\_\_\_ Home Phone No.: \_\_\_\_\_

Who referred you to our office: \_\_\_\_\_

What type of care do you desire:  Temporary Relief  Lasting Correction  Best Care Possible

## CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

When was the first time you noticed this problem:

\_\_\_\_\_  
\_\_\_\_\_

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: \_\_\_\_\_  
\_\_\_\_\_

Have you had any similar health problems or injuries before?  Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Names of all other doctors you have seen for this problem: \_\_\_\_\_  
\_\_\_\_\_

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):  
\_\_\_\_\_  
\_\_\_\_\_

Has your health problem been:  Improving  Worsening  Staying the Same

Please describe anything you do that improves your condition, or worsens it: \_\_\_\_\_  
\_\_\_\_\_

Please check off and describe how this problem interferes with your work and/or personal life:

Home Activities Effected: \_\_\_\_\_

Work Activities Effected: \_\_\_\_\_

Have you missed any work days?  Yes  No If yes, dates missed: \_\_\_\_\_

Recreational Activities Effected: \_\_\_\_\_

Rest or Sleep Effected: \_\_\_\_\_

## Dolmat Geheren Chiropractic Health History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Have you ever been diagnosed with, treated for or had indications of any of the following conditions?

If YES provide medical details at bottom of page.

Arthritis or rheumatism	yes	no
Asthma or other respiratory conditions	yes	no
Allergies	yes	no
Blood or circulatory problems	yes	no
Heart disease, angina	yes	no
High Blood Pressure *	yes	no
Heart attack	yes	no
Headaches or Migraines	yes	no
Cancer or tumor	yes	no
Epilepsy or seizures	yes	no
Disorders of spine, discs, joints, bones	yes	no
Colitis or intestinal problems	yes	no
Diabetes	yes	no
Diseases of eyes, ears, nose, throat	yes	no
AIDS or HIV	yes	no
Stroke	yes	no
Lupus	yes	no
Gallbladder disease or gallstones	yes	no
Kidney disease or kidney stones	yes	no
Liver trouble	yes	no
Paralysis	yes	no
Thyroid problem or goiter	yes	no
Ulcers or stomach trouble	yes	no
Emotional or mental condition	yes	no
Do you smoke?	yes	no
Other	yes	no

\* If "yes" indicate the following: Last reading \_\_\_\_\_  
Date of reading \_\_\_\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_, (patient's name) acknowledge that I have reviewed, received, understand and agree to the Notice of Privacy Practices of Dolmat & Geheren Chiropractic Clinic, which describes the Practice's policies and procedures regarding the use of any of my Protected Health Information created, received or maintained by the Practice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

**FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT**

The Practice has made a good faith effort to obtain an acknowledgement of \_\_\_\_\_ (patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

Patient Unavailable     Patient Physically Unable     Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to Provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

Personally     Mail     Other: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name of Physician

Dolmat & Geheren Chiropractic Clinic  
Name of Practice