# APPLICATION FOR TREATMENT

## PERSONAL INFORMATION

Name: _____ Today's Date: ____/____/____

Address: _____

E-mail Address: _____

Birth Date: ___/___/___ Age: _____ Are you Pregnant: ❒ Yes ❒ No

Employer's Name & Address: _____

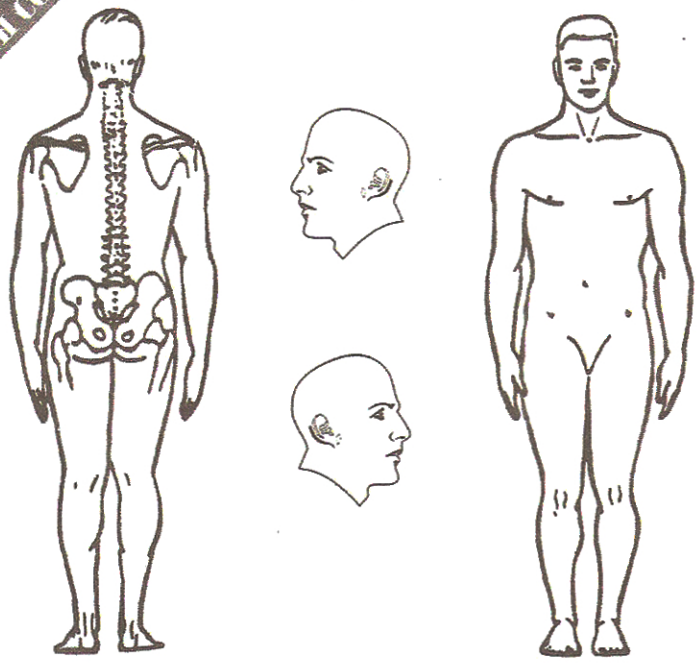
Occupation: _____ Work Phone No.: _____ Home Phone No.: _____

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: _____

(Please complete reverse side.)

## PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ❒ Yes ❒ No
If yes, please explain: _____

_____

_____

Have you ever received Chiropractic care? ❒ Yes ❒ No If yes, please list the doctor's name, location of office and for what problems: _____

_____

_____

Please check off the drugs you are now taking: ❒ Pain Killers ❒ Muscle Relaxers ❒ Anti-inflammatory
❒ Blood Pressure Medication ❒ Insulin ❒ Birth Control Pills ❒ Tranquilizers ❒ Diet Pills
❒ Nerve Medication ❒ Sleeping Pills ❒ Anti-depressants ❒ Other (please list): _____

_____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

_____

_____

If you have been in an automobile accident, when? ❒ This Year ❒ Last Year ❒ Past 5 Years ❒ Over 5 Years

Please check off the following that apply to you within the past 2 years: ❒ Went to a Health Spa
❒ Purchased Vitamins ❒ Purchased Health Foods ❒ Received a Massage
Please explain why you choose to do any of the above: _____

_____

## FAMILY HEALTH HISTORY

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Separated

Names & Ages of Children: _____

Name of wife or husband: _____

Spouse's Employer: _____ Business Phone: _____

## FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ❒ I am ❒ Spouse ❒ My Employer ❒ Insurance
❒ Other: _____

Type of Insurance: ❒ Worker's Comp. ❒ Health ❒ Automobile

Insurance Company's Name & Address: _____

_____

If you are responsible for your health care fees, payment will be made by: ❒ Cash ❒ Check ❒ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature _____ Social Security No.: _____ Date: ___/___/___

# MASTER 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 IKEDA FAMILY CHIROPRATIC, INC. (Office) such sums as may be due and owing this Office for services rendered to me, both by reason of an 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 payment benefits, No-Fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me, or from any settlement, judgement 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 settlement, judgement or 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 the 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 or cause of action as they see fit.

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

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Master 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 hereby state and agree that a photocopy of this document will be as valid and binding on all parties involved as the original copy.

Date: _____ Signed: _____