

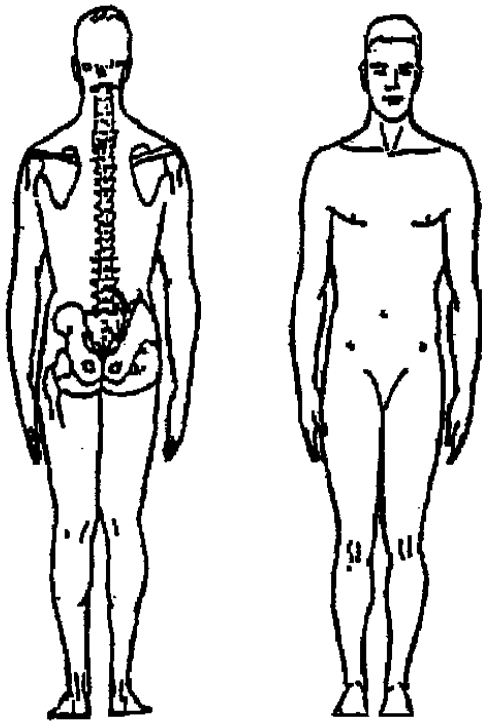
**INFORMATION/APPLICATION FOR CARE**

The following information is needed in order to better serve you. If you need help please ask the receptionist. PLEASE PRINT.

**PATIENT INFORMATION:**

Date \_\_\_\_\_ Name \_\_\_\_\_  
SS# \_\_\_\_\_ Driver's License ST \_\_\_ # \_\_\_\_\_

Referred to our office by: \_\_\_\_\_



**COMPLETE THESE DIAGRAMS**

If you are in pain, please mark the exact location of your pain on the diagram. 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, consistent, off & on, when standing, when sitting, etc.....

**MAJOR COMPLAINTS**

(Please list any condition you are being treated for or are experiencing.)

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

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

Is your condition due to an accident? Yes \_\_\_ No \_\_\_ Date of accident \_\_\_\_\_

Type of Accident? Auto \_\_\_ Work/On Job \_\_\_ At Home \_\_\_ Other \_\_\_\_\_

Have you ever been in an auto accident? Past Year \_\_\_ Past 5 Years \_\_\_ Over 5 Years \_\_\_ Never \_\_\_