THOMAS CHIROPRACTIC CARE

10252 SOUTH U S HWY 441
BELLEVIEW, FL 34420-6812
352-245-6169

APPLICATION FOR TREATMENT

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

☐ Check here if you want the Doctor to recommend the best type of care for you.

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone Number: _____ Phone at Work: _____

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

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

Where are you employed? _____ Spouse's Employer: _____

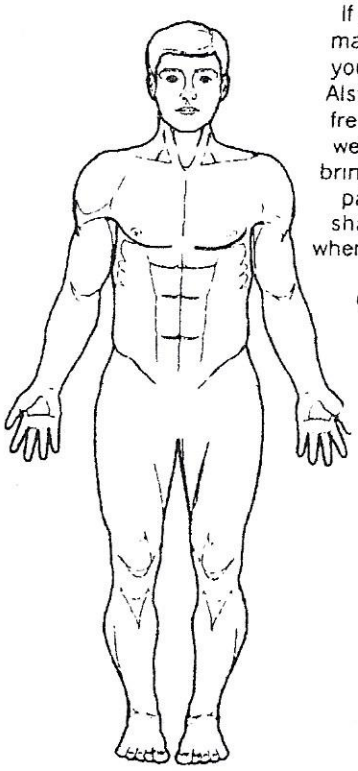
Your days off: _____ Referred to our office by: _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other _____

How Payment will be made: Type of Insurance _____

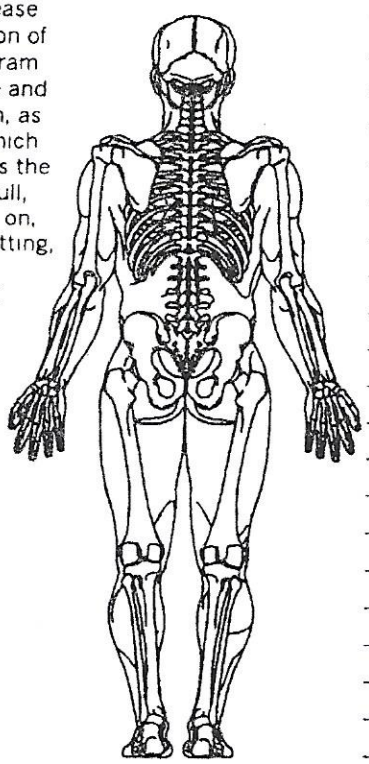
Cash _____ Workers' Comp. _____ Health Insurance _____

Check _____ Credit Card _____ Automobile Ins. Policy _____



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, constant, off & on, when standing, when sitting, etc , etc

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT

(Please describe only your major problem)

How did this condition develop? What caused it? How did it start?) _____

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? _____

(PLEASE COMPLETE REVERSE SIDE)