FAYETTE CHIROPRACTIC CENTER
Application for Treatment

Name_____ Home Phone_____
Age____ Date of Birth_____ Male__ Female__ SS_____
Street Address_____
City_____ State_____ Zip Code_____
Who may we thank for referring you to us?_____

Employer_____ Office Phone _____
Address_____
Occupation_____
Can you be contacted at work? Yes_____ No_____

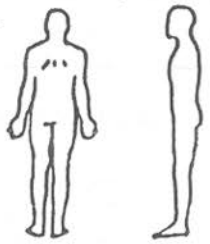
Name of Wife or Husband_____Occupation_____
Employer_____ Office Phone _____
Other Nearest Relative_____ Phone _____
Name and Ages of Children_____

Insurance Co._____Phone_____
Name of insured_____ Group Number_____
Insured's SS#_____Insured's Birthdate_____

DESCRIBE YOUR MAJOR COMPLAINT INCLUDING THE TYPE AND FREQUENCY OF YOUR PAIN. (Example; Dull, Sharp, Constant, When Sitting, When Standing, etc.)

_____
_____
_____
_____
_____
_____
_____

If you are in pain, mark the location of your pain.



Were you injured on the job? Yes___ No___ If yes: Date of injury_____ Claim Number_____
Contact person_____ Phone Number_____

Was this the result of an auto accident? Yes___ No___ If yes:
Date of accident_____ Claim Number_____
Was another automobile involved? Yes___ No___
Attorney's Name_____ Phone_____

Have you been involved in any accidents, falls, etc. that may have caused your problem? Yes____ No____ If so, please explain.

_____

Have you lost time from work because of this condition?
Yes___ No___ If yes, please give dates_____

Have you received any diagnosis or treatment for this condition?
Yes___ No___ If yes, where, when and what were your results?