HALE CHIROPRACTIC

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

Preferred Patient Name

_____

Date Completed

Patient Information

Full Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: Work Phone: ( ) Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

List your Chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Where is the pain? _____

Does the pain spread? □ Yes □ No If yes, where? _____

Do you have numbness? □ Yes □ No If yes, Where? _____

Indicate any function below that aggravate or are aggravated by your condition: (Circle all that apply)

Walking Step Climbing Driving Working Recreation Bowl Movements Digestion

Vision Breathing Sinuses Hearing Smelling Sleeping Menstrual Lifting

Have you ever been to a chiropractor before? □ Yes □ No If yes, when? _____

Medications your currently taking and dosage: (If listed give to receptionist to copy)

_____

_____

Medication Allergies: _____

Smoking Status: Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

If Smoker; year started: _____

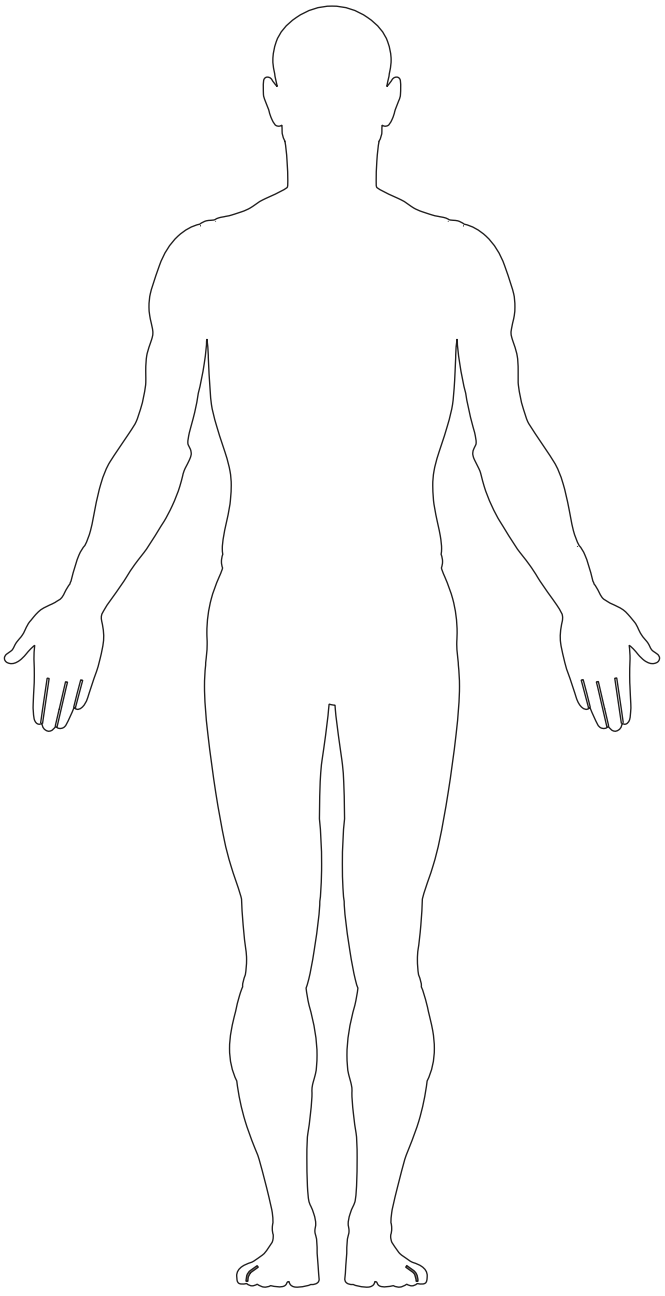
Father, Mother, Brother, Sister, Children with similar problems? □ Yes □ No If yes, who? _____

**** If you have insurance cards, please give them to the front desk to take a copy.**

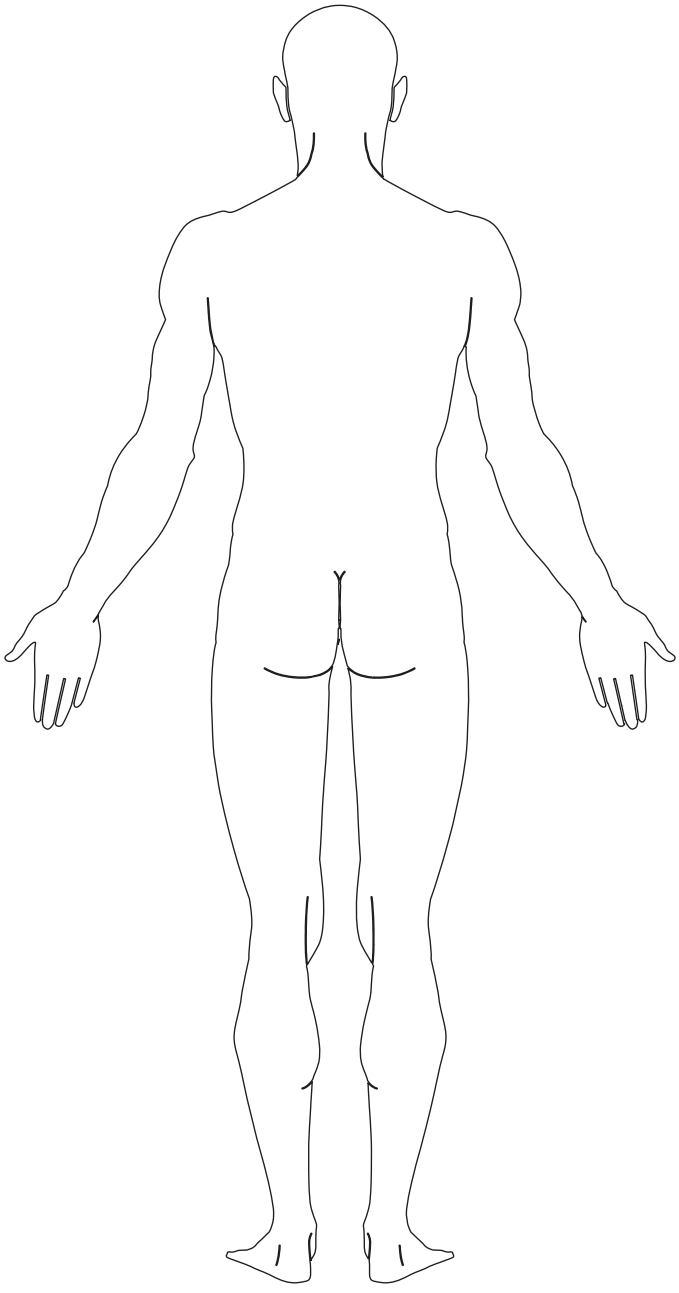
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE G = STABBING N = NUMBNESS B = BURNINGM = SPASMS T = TINGLING
P = PINS & NEEDLES F = STIFFNESS O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

_____

_____

_____

Consent to Treat a Minor Child

I hereby authorize Dr. James Hale and whomever he/she may designate as their assistant(s) to render treatment as he/she deems necessary to my:

Son/Daughter_____

Date:_____ Print Name:_____

Signature:_____

Signature is from child's:_____Parent_____Guardian