

Skocik Chiropractic P.C.
5431 Old Jonestown Road
Harrisburg, PA 17112
(717) 540-8448

APPLICATION FOR TREATMENT

Date _____

Name _____ Age _____ Birthdate _____

Address _____

City _____ State _____ ZIP Code _____

Email address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred to our office by _____

Check if you are: Married Single Widowed Divorced Separated

SS#: _____ Male Female

Employer _____

Occupation _____

Please describe the principal health problems for which you came to this office. _____

How and when did symptoms first occur? _____

List any other doctors seen for these problems _____

List diagnosis(es) and type of treatment(s) _____

Does this interfere with your normal living and work? Yes ___ No ___ In what way? _____

Have you lost any days of work? Yes ___ No ___ Dates _____

Have you had similar symptoms or injuries before? Yes ___ No ___ If yes, explain _____

List the names of any relatives that have or have had a similar problem _____

PAST HISTORY

Has a physician treated you for any health condition in the last year? Yes ___ No ___

If yes, explain: _____

Have you or any relative received Chiropractic treatment previously? Yes ___ No ___ If yes, explain _____

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) _____

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) _____

FAMILY HISTORY

Name of wife or husband _____ Ages of children _____

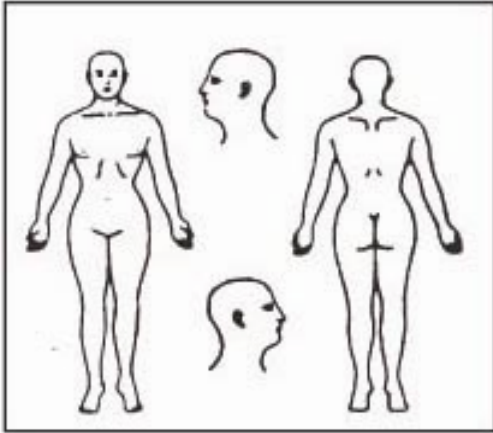
If Female, are you now or do suspect you are pregnant? Yes No

Spouse's Employer _____ Business Phone _____

Your Nearest Relative _____

Relative's Address _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

- 1. _____
- 2. _____
- 3. _____
- 4. _____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient _____ Social Security Number _____

1. Rate the level of severity of your current problem. (One not so severe, five very severe.)

- 1 2 3 4 5

2. How well do you feel chiropractic can help your current problem? (One not so well, five very well.)

- 1 2 3 4 5

3. Please mark any wellness problems you may have.

- | | | |
|--|--|--|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chronic aches and pains | <input type="checkbox"/> Other: _____ | |

4. How interested are you in chiropractic in relation to fixing your indicated wellness issue? (One is not interested, five is very interested.)

- 1 2 3 4 5

5. Have you ever been to a chiropractor before? Yes No

6. Have you seen any other type of doctor for this problem? Yes No

7. Rate you previous chiropractic experience. (One is not good, five very good.)

- 1 2 3 4 5