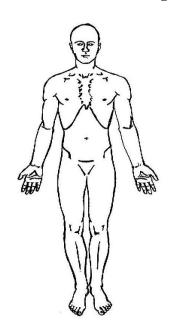
FARE CHIROPRACTIC APPLICATION FOR TREATMENT General Patient Information

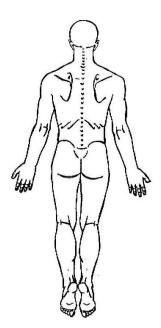
LAST NAME	FIRST		MI	
LAST NAME	AGE SEX MALE / FE	MALE RAC	E:	
MAILING ADDRESS				
MAILING ADDRESS CITY HOME PHONE#()	STATE		ZIP	
HOME PHONE#()	_CELL#()	WORK#()	
WHICH OF THE ABOVE PHONE NUM CALLS?	BERS WOULD YOU LIKE TO	RECEIVE YOU	R REMINDER	
	HOMEV			
IF YOU ARE UNABLE TO ANSWER YO		E PERMISSION	TO LEAVE YOU A	
MESSAGE?YESN	NO			
MARTIAL STATUS: M S D W				
IN CASE OF EMERGENCY CONTACT		PHONE # ()	
RELATIONSHIP:		(/	
HOW DID YOU HEAR ABOUT OUR		-		
OFFICE?		_		
WHO IS YOUR FAMILY DOCTOR?				
MAY WE HAVE PERMISSION TO CON	ISULT WITH THEM ABOUT Y	OUR CARE?	YESNO	
***********	***********	*****	********	
	History of Complaint(s)			
PLEASE CHECK ALL ANSV	WERS AND FILL IN BLANKS	WHERE APP	ROPRIATE.	
5				
Describe the problem(s) which brings you	•			
1				
3				
5	6			
Pain Drawing				

Please Mark all of the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of

radiation. Include all affected areas.

Pain = PStiffness = SBurning = BNumbness = NTingling = T





Please describe the character of your current pain (You may check one or more answers): _Sharp/stabbing _Aching _ Dull/diffuse _ Constricting _ Weakness _Throbbing/gnawing	How bad is your pain or complaint? (Please circle one) B=Best W=Worst A=Average NOPAIN ← N	PATIENT NAME DATE//
Please describe the character of your current pain (You may check one or more answers): _Sharp/stabbing _Aching _ Dull/diffuse _ Constricting _ Weakness _Throbbing/gnawing	Please describe the character of your current pain (You may check one or more answers):	
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Sharp/stabbing	Sharp/stabbing	
Numbness Shooting Burning Tingling Other How often are the complaints present? Constant (76-100%)Frequent (51-75%)Occasional (26-50%)Intermittent (25% or less) How bad is your pain or complaint? (Please circle one)	Numbness _Shooting _Burning _Tingling _Other _ How often are the complaints present? _ Constant (76-100%) _Frequent (51-75%) _Occasional (26-50%) _ How bad is your pain or complaint? (Please circle one) _ 0 1 2 3 4 5 6 7 8 9 10	Sharp/stabbing Aching Dull/diffuse Constricting Weakness Throbbing/gnawing
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	Inactivity Nothing Other (Please specify)	

PATIENT NAME	DATE//
Problem/Complaint 2(cont'd):	
What activity/activities are you unable to perform without pain? (please personal grooming / driving / walking / sitting / standing / sleeping / delivery of the problem by another healthcare proved the second of the problem by another healthcare proved the second of the problem by another healthcare proved the second of the second of the problem by another healthcare proved the second of t	exercising / bending / lifting rider?Yes No pist/PT Emergency room/ER
Have you had x-rays, an MRI or any other special tests?Ye	s No Please list:
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Have you had x-rays, an MRI or any other special tests?Ye	es No Please list:

PATIENT NAME	DATE//
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Have you had x-rays, an MRI or any other special tests?	Yes No Please list: What is your present weight? pounds