



810 E. Main St., Richmond, MO 64085
(816)776-3302

APPLICATION FOR TREATMENT

Date \_\_\_\_\_ How did you hear about Jordan-Dunivent Chiropractic? \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone Number
\_\_\_\_\_ Phone at Work \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Check if you are: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

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

How and when did symptoms first occur? \_\_\_\_\_

Family Medical Doctor \_\_\_\_\_

List any other doctors seen for these problems \_\_\_\_\_

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes \_\_\_\_\_ No \_\_\_\_\_ Address \_\_\_\_\_

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 \_\_\_\_\_

Who to contact in case of an emergency? \_\_\_\_\_

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 \_\_\_\_\_

Do you have a history of stroke or hypertension? \_\_\_\_\_ Do you smoke? Yes No If Yes, how much per day? \_\_\_\_\_

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.) \_\_\_\_\_

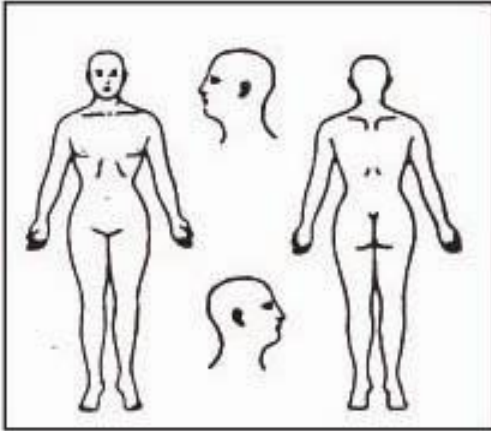
How many days a week do you exercise? [ ] none [ ] 1-2 [ ] 3-4 [ ] 5-7

Are you, or do you think, you might be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY HISTORY**

Name of wife or husband \_\_\_\_\_ Ages of children \_\_\_\_\_  
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. \_\_\_\_\_

Who is responsible for your bill? Self \_\_\_\_ Spouse \_\_\_\_ Employer \_\_\_\_

Please check any and all insurance coverage that may be applicable in this case:

- Health Insurance  Worker's Compensation  Medicaid  Automobile Ins. Policy
- Medical Savings Account & Flex Plans  Other

Name of Primary Insurance Company: \_\_\_\_\_

Name of Secondary Insurance Company: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due to and payable. Fees are payable at the time of examinations and treatments are received unless other arrangements are made in advanced.

**The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_