THE CHIROPRACTIC OFFICES OF DR. GUY YVES PELCHAT, D.C.

Application For Treatment

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Last Name	First	Middle	Today's Date
Address	City	State	Zip

Age	Birthdate	Sex	Marital Status	No. of Children	Home Phone	Cell Phone

Employer	Address	Business Phone

Occupation

Who referred you to us?	In case of Emergency Notify (Local Contact)	Relationship	Phone

Person responsible for this account

Major Complaint (List your symptoms)

Have you had the same or similar conditions in the past ❑Yes ❑No | How long ago?

How long have you had this condition? Is it getting worse ❑Yes ❑No | Does it bother your ❑Work ❑Sleep ❑Other

What seemed to be the initial cause? | Rate severity of pain on a scale from 1 (least pain) - 10 (worst pain imaginable!)

Have you had any treatment of this condition?

Have you seen a chiropractor before ❑Yes ❑No (If yes for how long) | For what reason:

Family Doctor | Are you under care of a physician ❑Yes ❑No (If yes for what?) | May we contact him/her ❑Yes ❑No

Drugs you now take: ❑Birth control ❑Tranquilizers ❑Pain Killers ❑Others Please List:

How is most of your daytime spent? ❑Standing ❑Sitting ❑Walking ❑Other

Have you ever:

Had surgery? .....❒ Yes ❒ No
Had a broken bone? .....❒ Yes ❒ No
Had strains, sprains or accidents? .....❒ Yes ❒ No
Used a cane, crutch or other support? .....❒ Yes ❒ No
Been struck unconscious?.....❒ Yes ❒ No
Been hospitalized for other than surgery?.....❒ Yes ❒ No
Had any implants (pacemaker, artificial limbs, etc.)? .....❒ Yes ❒ No
Had a stroke? .....❒ Yes ❒ No

Do You:

Take minerals, herbs or vitamins?.....❒ Yes ❒ No
Have any drug allergy? .....❒ Yes ❒ No

When did you have:

Spinal X-Ray .....❒ Never ❒ 0-6 mo. ❒ 6-18 mo. ❒ Longer
Spinal examination .....❒ Never ❒ 0-6 mo. ❒ 6-18 mo. ❒ Longer

If yes, briefly explain why:

CHECK SYMPTOMS YOU HAVE NOTICED

- ❒ Headache
- ❒ Neck Pain
- ❒ Neck Stiffness
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Pain Down legs
- ❒ Dizziness
- ❒ Head Seems Too Heavy
- ❒ Pins & Needles in Arms
- ❒ Pins & Needles in Legs
- ❒ Numbness in Fingers
- ❒ Numbness in toes
- ❒ Buzzing in Ears
- ❒ Fatigue
- ❒ Depression
- ❒ Pain Down Arms
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Hip Pain
- ❒ Loss of Balance
- ❒ Fainting Spells
- ❒ Weakness in Arms & Hands
- ❒ Weakness in Legs & Feet
- ❒ Other _____
- ❒ Other _____

EXERCISE

- ❒ None
- ❒ Moderate
- ❒ Daily
- ❒ Heavy

WORK ACTIVITY

- ❒ Sitting
- ❒ Standing
- ❒ Light Labor
- ❒ Heavy ILbor

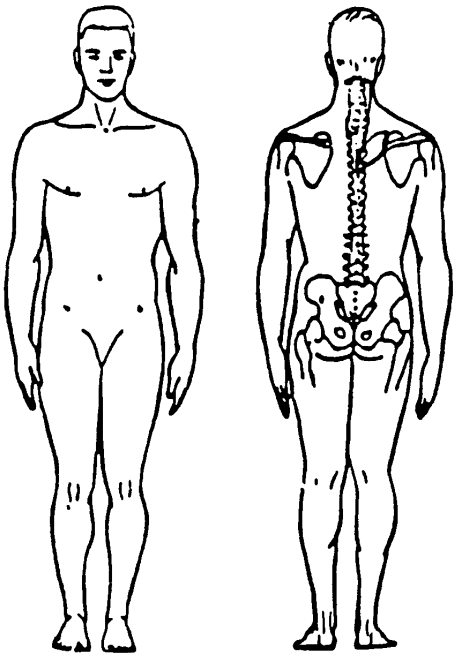
HABITS

- ❒ Smoking
- ❒ Alcohol
- ❒ Coffee/Caffeine Drinks
- ❒ High Stress Level
- ❒ Packs/Day _____
- ❒ Drinks/Weeks _____
- ❒ Cups/Day _____
- ❒ Reason _____

FAMILY HISTORY OF ANY ILLNESSES:

ADDITIONAL COMMENTS:

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which aggravates or brings on the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc. **COMPLETE THESE DIAGRAMS**



ARE YOU PREGANT? YES NO

IF YES, HOW LONG? MOS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Pelchat Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paiddirectly to the Pelchat Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that if I am accepted as a patient by the physician of Pelchat Chiropractic Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

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Patient Signature