

**APPLICATION FOR TREATMENT**

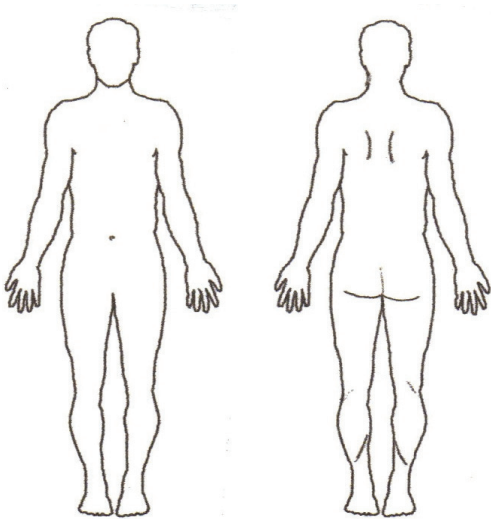
Name: \_\_\_\_\_ Date of Birth: MM/\_\_\_\_ DD/\_\_\_\_ YY/\_\_\_\_ Sex: M F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ Spouses Name (If married): \_\_\_\_\_  
 Employer: \_\_\_\_\_ Spouses Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_ Ages of Children (If any): \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Please print and circle areas of complaint below and on a scale of 1-10 (10 being the worst) rate your discomfort.

**Major Complaint**

Please describe your main problem briefly



When did you first notice this problem? \_\_\_\_\_  
 How did that problem begin? \_\_\_\_\_  
 Since that time, has it been (check one)  
     Getting Better    Getting Worse    Staying the Same  
 Have you seen a doctor for this condition?    Yes    No  
 If yes, Doctor Name and Phone #: \_\_\_\_\_  
 Have you lost time from work due to this condition?    Yes    No  
 If yes, from \_\_\_\_\_ to \_\_\_\_\_

Have you done anything for it that seems to help? \_\_\_\_\_  
 Have you ever been involved in an auto accident, sports injury, bad fall or other significant injury? \_\_\_\_\_  
 Do you have any known allergies (including medication)? \_\_\_\_\_  
 Have you ever been diagnosed as having or suffering from: (check all that apply)

- |                         |                      |                           |                      |            |
|-------------------------|----------------------|---------------------------|----------------------|------------|
| Osteoarthritis          | Eating Disorder      | Broken or fractured Bones | Epilepsy             | Alcoholism |
| Circulatory Problems    | Pacemaker            | Drug Addiction            | Rheumatoid Arthritis | Stroke     |
| HIV Positive            | Seizures/Convulsions | Cancer / Tumors           | Gall Bladder         | Ulcers     |
| Congenital Disease      | Diabetes Type I / II | Excessive Bleeding        | Depression           | Smoking    |
| High/Low Blood Pressure | Sprain/Strain        | Coughing Blood            | Other: _____         |            |

*All fees are payable at the time services are rendered unless other arrangements have been made. X-rays remain the property of this clinic*

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