PATIENT APPLICATION FOR TREATMENT

Last name:	First:	MI:	Gender ☐ M ☐ F
Email:	Date of Birth:		Age:
Your address:	City:		State:
Zip:	Home #	Cell #	
Prior Occupation:	Present Occupation:		Wk #
Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐			
Emergency Contact?	Phone #		Relation:
How many children do you have?	What are their ages?		
Have you ever had chiropractic care? ☐ Yes ☐ No How long has it been?			
Has anyone else in your family ever had chiropractic care? ☐ Yes ☐ No			
Do you smoke: ☐ Yes ☐ No How much?	Do you exercise: ☐ Yes ☐ No How much?		
What is the purpose or reason for this appointment?			
When do you notice it most? ☐ AM ☐ PM	Have you ever had this in the past? ☐ Yes ☐ No		
What makes it feel better?	What makes it feel worse?		
(Females only) Are you pregnant? ☐ Yes ☐ No			

Using the scale below, indicate the **severity** of your **main complaint** (when at its worst)

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

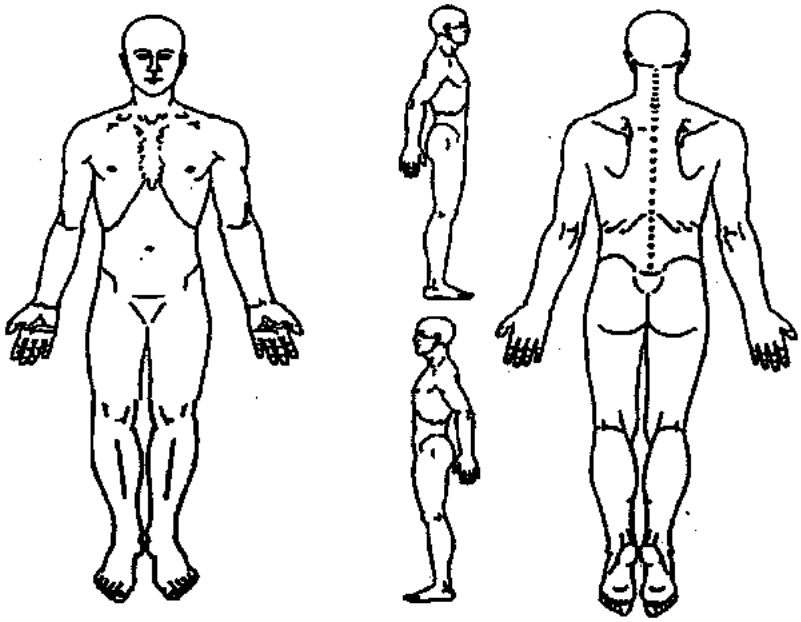
Using the scale below, indicate the **percentage of time** you experience your **main complaint**:

		Occasional		**Intermittent**		**FREQUENT**		**CONSTANT**		
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint**?

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING PAIN **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



Wellness 1st Integrative Medical Center, LLC

Patient Consent to Treatment Form

I hereby acknowledge the communications put forth and description of my condition(s)/ diagnosis, presenting signs and symptoms, pertinent evaluation report of findings, contraindications and precautions to treatment, expected benefits of treatment, and reasonable alternatives to treatment when applicable by a Wellness 1st clinician. I further acknowledge that my consent to receive treatment was voluntary and obtained following my initial evaluation that was performed for determination of the appropriateness of my plan of care/ treatment program.

I understand that I have the right to ask questions and receive adequate response to my questions at any time during the course of my care; and that I can terminate at any time I wish to discontinue.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____