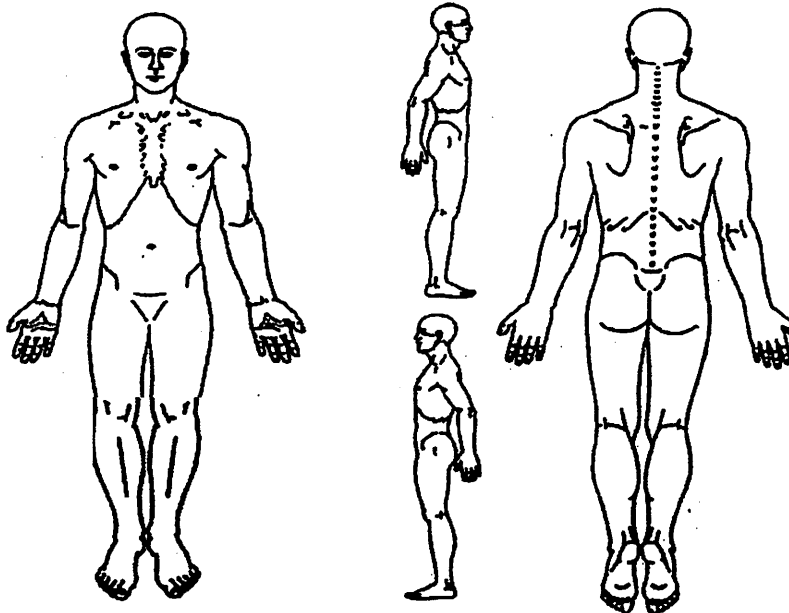


PATIENT APPLICATION FOR TREATMENT

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