CONFIDENTIAL APPLICATION FOR CARE

(Please Print) (PLEASE FILL IN ALL BLANKS) Date:______________________

Full Name______________________________ I prefer to be called______________

Address ______________ City______________ State________ Zip ___________

Home Phone__________ Work Phone______________ Mobile/Pager______________

Social Security #______________ Birth date__________ Age______ Sex: M / F

Employer______________ Occupation______________ Days off S M T W TH F S

Referred to our office by______________ Marital Status Married/Single/Divorced/Separated/Widow

Spouse's Name______________ Birth date ________ Social Security #______________

Who is responsible for your bill?_____Self____Spouse______Employer______Insurance______Other

How will payment be made?

_______Cash _____Credit_______Health Insurance

_______Check _____Worker's Comp_____Auto Insurance

Name and Address of Insurance Company

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CURRENT HEALTH CONDITION

What is the reason for this visit?______________________ Date Started __________

Secondary Complaint______________________ Date Started __________

Other Complaint______________________ Date Started__________

Please check all symptoms you have noticed now (present) or in the past.

Past/Present	Past/Present	Past/Present	Past/Present
☐/☐ Head feels heavy	☐/☐ Pins and needles in arms	☐/☐ Frequent colds	☐/☐ Frequent urination
☐/☐ Neck pain	☐/☐ Numbness in fingers	☐/☐ Motion sickness	☐/☐ Urinary infections
☐/☐ Jaw Pain	☐/☐ Numbness in toes	☐/☐ Light bothers eyes	☐/☐ Prostate problems
☐/☐ Mid back pain	☐/☐ Stroke	☐/☐ Vision blurred	☐/☐ Cancer
☐/☐ Back pain	☐/☐ Chest Pain	☐/☐ Dry skin	☐/☐ Impotent
☐/☐ Heel Spurs	☐/☐ Hands/Feet turn Blue	☐/☐ Eczema	☐/☐ Fatigue
☐/☐ Arthritis	☐/☐ Hands/Feet get cold	☐/☐ Excessive perspiration	☐/☐ Loss of appetite
☐/☐ Joint stiffness	☐/☐ Light headed	☐/☐ Nail Fungus	☐/☐ Excessive appetite
☐/☐ Joint Pain	☐/☐ High blood pressure	☐/☐ Allergic to __________	☐/☐ Diabetes
☐/☐ Muscle cramps	☐/☐ Heart skips beats	☐/☐ Stomach upset	☐/☐ Unexplained weight loss
☐/☐ Muscle tension	☐/☐ Rapid heart beats	☐/☐ Constipation	☐/☐ Unexplained weight gain
☐/☐ Headaches	☐/☐ Varicose veins	☐/☐ Diarrhea	☐/☐ Night sweats
☐/☐ Dizziness	☐/☐ Asthma	☐/☐ 1 or less bowel movements/day	☐/☐ Difficulty concentrating
☐/☐ Double vision	☐/☐ Difficulty breathing	☐/☐ Heartburn	☐/☐ Depression
☐/☐ Hands tremble	☐/☐ Loss of taste	☐/☐ Nausea	☐/☐ Nervousness
☐/☐ Loss of balance	☐/☐ Loss of smell	☐/☐ Bed wetting	☐/☐ Irritable
☐/☐ Loss of memory	☐/☐ Trouble swallowing	☐/☐ Bladder control problems	☐/☐ Hyperventilate
☐/☐ Muscle twitching	☐/☐ Ear noises/ringing	☐/☐ Difficulty starting urination	☐/☐ Other__________

Describe any accidents, falls, etc., that might have caused your problem?______________________

Is this complaint from car accident? Yes / No Date ______________ Have you reported it? Yes/ No

Is this complaint from a work accident? Yes / No Date ______________ Have you reported it? Yes/ No

Please list other doctors seen for complaints:

1.________________________________When?______________________Diagnosis?___________________________

2.________________________________When?______________________Diagnosis?___________________________

Who is your family doctor?___________________________ May we send a copy of our findings to him/her? Yes / No

Please list any medical problems for which you regularly see a doctor such as high blood pressure, diabetes, etc.

____

Do you exercise regularly? Yes / No Type____________________ Frequency______________Hours sleep/Night ______

Overall, how healthy is your diet? _____Excellent_____Good _____Fair_____Poor Water intake daily?____________

Tobacco use? Yes / No Frequency______________________ Alcohol use? Yes/No Frequency____________________

Caffeine use? Yes/No Frequency_______________ History of recreational drug use? Yes / No Type _______________

Medications currently taken [Please list all drugs (including nonprescription, vitamin and herbal supplements)]

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

For women only: Are you on birth control pills? Yes / No Are you pregnant? Yes / No Date of last period_____________

PAST HEALTH HISTORY

Have you ever been in an automobile accident? ____Past year ______Past 5 years ____Over 5 years ____Never

Any other past accidents, trauma or falls (with dates)? ____

Surgical: (Please list all surgeries with their dates even if unrelated to today's visit.)_______________________________

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Family medical history (list ages and diseases)

Mother (Age)_____ (Disease)____

Father (Age)_____ (Disease)____

Other relations (Age)_____ (Disease)____

Previous chiropractic care (other than Dr. Walicki): Physician's name____

Date of first visit____________________Were X-Ray's taken? Yes/ No Date of last visit__________________________

Is there anything else we should know about your health?____

Why Chiropractic? People go to chiropractic physicians for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the symptoms relieved along with the problem corrected with specific exercises (Corrective Care). Still others want their health optimized by going beyond corrective care with additional nutritional, exercise or lifestyle recommendations (Comprehensive Care). We will weigh your need and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care ☐ Doctor to select type of care appropriate for my condition.

INFORMED PATIENT CONSENT

I understand that if I am accepted as a patient of Dr. Walicki, I authorize him to proceed with any further treatment that may be necessary, any risks involving Chiropractic treatment will be explained to me upon request.

Patient's Signature:____ Date:____________________

Parent's or Guardian's:____ Date:____________________

Signature Authorizing Care:____