

Date _____

MINOR PATIENT APPLICATION FOR TREATMENT

LAST NAME _____

FIRST NAME _____

HOW WOULD YOU LIKE TO BE ADDRESSED? _____

DATE OF BIRTH: _____ AGE _____

GENDER: M OR F SSN: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

EMAIL ADDRESS _____

MARRIED SINGLE DIVORCED WIDOWED

SCHOOL ATTENDING: _____

LEGAL GUARDIAN NAME: _____

ADDRESS: _____ PHONE NO _____

INSURED NAME: _____

PRIMARY INSURANCE _____

INSURED DATE OF BIRTH _____

POLICY#: _____

INSURED SSN: _____

SECONDARY INSURANCE: _____

INSURED OCCUPATION _____

POLICY#: _____

INSURED WORK NO. _____

PRIMARY CARE PHYSICIAN: _____

PRIMARY CARE PHYSICIAN NO.: _____

WHEN WAS YOUR LAST PHYSICAL EXAM _____

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU EXERCISE? YES NO HOW OFTEN? _____ WHAT TYPE: _____

WHAT IS YOUR CHIEF COMPLAINT? _____

How long has your problem been going on? ___Hours ___Days ___Weeks ___Months ___Years

Have you seen any other doctors for this condition? Yes No If yes, please specify type of Doctor: _____

Have you had an MRI? Yes No If yes, what was the date of your MRI and where? _____

Were you diagnosed with any herniated disc? No Yes Not Sure If yes, what disc levels? _____

Have you had any spinal surgeries? Yes No If yes, specify what type; _____

If yes were there any hardware such as rod, screws or wires inserted into you spine during surgery? Yes No N/A

Is your condition affecting your: Job Performance Relationships Exercises Hobbies Other _____

How would you life be affected if your problem got worse? _____

Is there anything specific you can no longer enjoy because of your condition? _____

If the doctor determines your child is a candidate for care, how committed are you to getting the problem fixed on a scale of 1-10 (1 = not committed at all/10 = totally committed)? 1 2 3 4 5 6 7 8 9 10

Is your child currently experiencing: Neck pain Neck stiffness Headaches Shoulder pain Radiating arm pain
 Arm/Hand Tingling & Numbness Low back pain Radiating Pain into buttock Radiating pain down one leg Radiating pain down both legs Muscle Weakness Pain While Sneezing or coughing Bowel or Bladder problems

Have you ever suffered from or been diagnosed as having : (circle Yes or No)

- | | | |
|-----------------------------------|--------------------------|--------------------------|
| Y N Broken-fractured bones | Y N Circulatory Problems | Y N Anxiety |
| Y N Epilepsy | Y N Tumors | Y N Coughing blood |
| Y N Cancer | Y N Depression | Y N Seizures/Convulsions |
| Y N Congenital Disease | Y N Diabetes | Y N Excessive bleeding |
| Y N High/low blood pressure | Y N Hands/Feet cold | Y N Speech Difficulty |

Identify with a (C) conditions you have now, or with a (P) the conditions you have had in the Past, if neither apply, mark (NA), Leave No Blanks.

High Blood Pressure____, Dizziness/Fainting____, Insomnia____, Tension____, Confusion____, Fatigue____, Ulcers____, Eye/Vision Problems____, Ear/Hearing Problems____, Difficulty Breathing____, Heart Problems____, Loss of Bladder Control____, Constipation____, Diarrhea____, Digestion Problems____, Nausea____, Female Problems____, Prostrate Problems____,

Parent/Guardian signature _____ Date _____