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_____________________________________