FIORINI CHIROPRACTIC CENTER

(850) 656-2200

APPLICATION FOR TREATMENT

Date: _____

Name: _____ **Date of Birth**: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Social Security #: _____ **Check if you are**: □ Married □ Single □ Widowed □ Divorced □ Separated

Employer: _____ **Occupation:** _____

E-mail Address: _____ **Spouse Name:** _____

Who is responsible for your bill? □ Self □ Spouse □ Employer □ Insurance (W/C, Health, Auto) **Primary Doctor:** _____

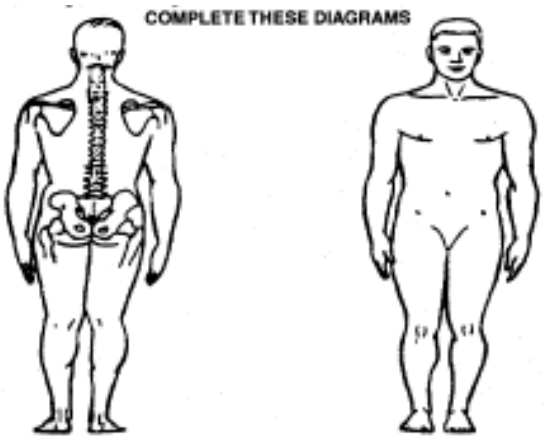
How payment will be made: □ Cash □ Check □ Credit Card **Type of Insurance:** □ Workers' Comp □ Health Insurance □ Auto Insurance Policy

If Auto, date of accident: _____ **Auto Insurance Company:** _____

Claim #: _____ **Adjuster Name:** _____ **Adjuster Phone #:** _____

Attorney Name: _____ **Attorney Phone #:** _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also, describe the type and frequency of your pain as well as activity which brings on or aggravates the pain. For example: dull, sharp, constant, off and on, when standing, when sitting, etc.



MAJOR COMPLAINT
(Please describe only your major problem)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Preferred Language?
□ English
□ Spanish
□ Other _____

Height: _____ feet _____ inches

Weight: _____ lbs. **Hand:** □ Left □ Right

Race?
□ I do not wish to provide this information. □ White □ Black or African American □ American Indian or Alaskan Native □ Asian
□ Native Hawaiian or Other Pacific Islander □ Other _____

Ethnicity?
□ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Other _____ □ I do not wish to provide this information.

Smoking Status?
□ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoker

Do you have any medication allergies?
□ No known medication allergies □ Yes. What? _____

Are you currently taking any medications?
□ Not currently prescribed any medications.
□ Yes …

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

Patient's Signature: _____ **Date:** _____