Application for Treatment

Back & Neck Care Center

Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Marital Status: M S W D Daytime Phone_____Evening_____

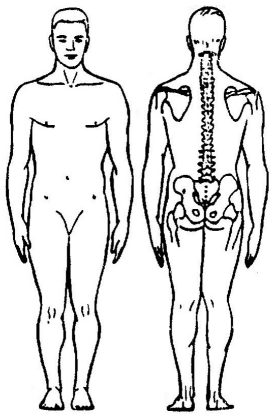
Email address: _____

Occupation _____Ages of Children_____

Place of Employment _____

Payment method: ___Cash ___Insurance ___Check___Credit Card ___Auto ___Work Comp.

Please mark the exact location of your pain on the diagram below, describing the frequency, as well as any activity that brings on or aggravates the pain. Example: *stabbing, dull, constant, aching, burning, numbness*



Major Complaint

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Ever been to a chiropractor? ___Yes ___No

Ever had a vehicle crash injury? ___Yes ___No

Ever had a work-related injury? ___Yes ___No

Fees are payable at the time service is rendered unless other arrangements are made in advance.
I hereby authorize and request any person to whom this authorization is presented to furnish Back & Neck Care Center, LLC any x-rays, records or reports concerning my illness. I also authorize Back & Neck Care Center, LLC to furnish information concerning my present illness or injury and direct the insurer to pay without equivocation, directly to Back & Neck Care Center, LLC any and all benefits due them as a result of this claim. I am also aware that I am personally responsible for charges and/or balances not covered by my insurance. I hereby state and agree that a photocopy of this document will be valid and binding on all parties.

***Patient Signature*_____*SS#*_____*Date* _____

Back & Neck Care Center
Medical History Form

Mitchell F. Miglis, D.C., Cert. MDT

Past Medical History and Review of Systems: Age_____ Height _____ Weight _____

Current Primary Care Doctor _____

What do you currently do for exercise? _____
_____

How is most of your day spent? ___Standing ___Sitting ___ Walking ___ Lifting/Carrying

Have you had MRI, CT scan, X-rays? ____No ____ Yes: When/Where _____

Are your symptoms interfering with: ____Work ____Sleep ____Activities/Sports ____Home Life

Have you seen any other healthcare providers (MDs PTs, etc.) for this condition? ___No ___Yes

Please describe:_____
_____
_____

Medications

Please list medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____

Recent Symptoms

Have you recently had any of the following?:

___Fever, chills, night sweats
___Unexplained weight loss
___Recent infection (for example: urinary track)
___Prolonged steroid use
___Intravenous (IV) drug use
___Pain which awakens at night
___Absence of or unusual sensation in area around the anus
___Bowel or bladder dysfunction (urinary retention, incontinence)
___Any history of recent trauma or injury not reported on your Application for Treatment?

Medical History for Illness or Condition that applies to you:

___Heart Attack	___Blood clots	___Unexplained weight loss	___HIV
___Heart trouble	___Anemia	___Bladder disorders	___Birth defects
___Cancer	___Hepatitis	___Bowel disorders	___Chest Pain
___Stroke	___Ulcers	___High blood pressure	___Sickle cell
___Diabetes	___Fever	___Bleeding disorders	___Cough
___Gout	___Anemia	___Lung disease	___Other _____

Smoker ___Yes ___No Alcohol use: ___Yes ___No Other drug use: _____

Family History

Please check (X) next to any disease or condition diagnosed in your blood relatives:

___Arthritis	___Heart disease	___Rheumatoid arthritis	___Diabetes
___Gout	___Cancer	___Back or neck problems	___Bleeding problems

Patient Name_____Patient Signature_____Date:_____