BENDER CHIROPRACTIC

APPLICATION FOR TREATMENT

(PLEASE PRINT)

Date: _____

Name: _____ Email: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Marital Status (circle one): Single Married Divorced Widowed

Where are you employed? _____ Spouses Name: _____

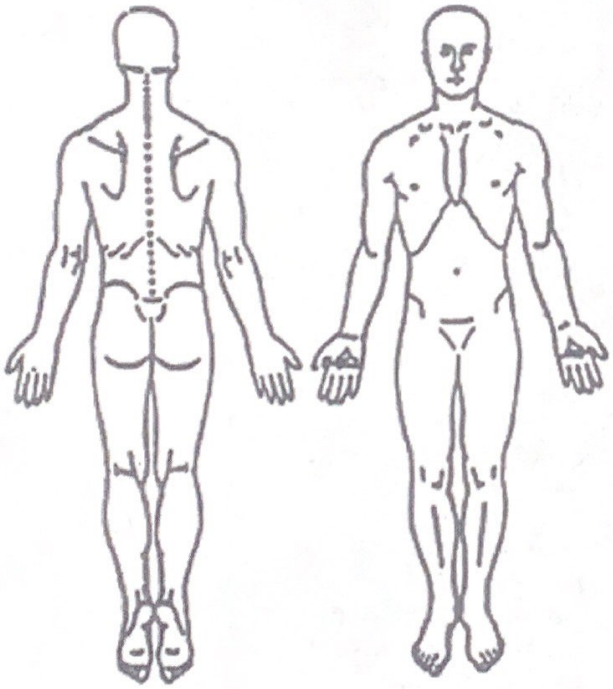
Who referred you to our office? _____

Please tell me your reason for consulting my office. _____

SECTION A

If you are in pain, please mark the location on the human diagrams and explain.

*If no pain, skip to Section B.



How did this condition develop? How and when did it start? _____

When were you first aware of this problem? _____

Have you ever had this or a similar problem before? Explain. _____

PLEASE COMPLETE REVERSE SIDE

Have you ever received any treatment for this condition? Where and what were the results? _____

_____

Has this problem been getting better, worse or staying the same? _____

Is there anything that makes your condition better or worse? _____

Have you ever been in an automobile accident? _____ How long ago? _____

Any falls, accidents, etc., that may have caused your problem? _____

_____ Are you pregnant? _____

Any chiropractors consulted in the past? NAME: _____

Date consulted: _____ For what problem: _____

SECTION B

Please list all medication you are currently taking and why. _____

_____

Please list all surgeries. _____

Do you now have or ever been diagnosed with any of the following? (***circle and explain***)

- Cancer
- Stroke
- Seizures
- Other _____
- Diabetes
- Heart Disease
- Autoimmune Disorder
- Other _____
- High Blood Pressure
- Thyroid Problems
- Allergies
- Other _____

Explain: _____

_____

Do you have a family history of any of the above? (Circle one) Yes No If yes, explain: _____

_____

On a scale of 0-5, **circle** the severity of your symptoms.

	None					Very Severe		None					Very Severe
Brain Fog	0	1	2	3	4	5	ADD (kids)	0	1	2	3	4	5
Muscle Loss	0	1	2	3	4	5	Gout	0	1	2	3	4	5
Fat Gain	0	1	2	3	4	5	Afternoon Tiredness	0	1	2	3	4	5
Depression	0	1	2	3	4	5	Funny Taste in Mouth	0	1	2	3	4	5
Problems Sleeping	0	1	2	3	4	5	Loss of Appetite	0	1	2	3	4	5
Trouble Losing Weight	0	1	2	3	4	5	Diarrhea/Constipation	0	1	2	3	4	5
Chronic Pain	0	1	2	3	4	5	Cravings (Sugar & Salt)	0	1	2	3	4	5
Chronic Fatigue	0	1	2	3	4	5	Mood Swings	0	1	2	3	4	5
Diabetes	0	1	2	3	4	5	Loss of Interest	0	1	2	3	4	5
Blood Sugar Problems	0	1	2	3	4	5	Digestion Problems	0	1	2	3	4	5
Memory Loss	0	1	2	3	4	5	Foot Fungus	0	1	2	3	4	5
Balance Problems	0	1	2	3	4	5	Fungal/Yeast Problems	0	1	2	3	4	5
Joint Pain	0	1	2	3	4	5	Low or No Sex Drive	0	1	2	3	4	5
Pain in Heel or Arch	0	1	2	3	4	5	Erectile Problems	0	1	2	3	4	5

While we are happy to file insurance claims for you, please remember that we are filing as a courtesy to you. We reserve the right to decline to file or to not participate with particular plans even if we have filed in the past. Changes in fee schedules and low insurance payouts may result in us dropping particular plans. We apologize for the inconvenience, but we will no longer be filing paper claims since the NCFA 1500 forms required to file are no longer available for free online. Also, due to the nature of frequent buy-outs by bridge plans and gap plans (resulting in unpaid claims), we will no longer file those claims either.

Thank you for your understanding. We will be happy to provide you with billing codes if you want to file on your own for possible re-imbursement.