INFORMATION / APPLICATION FOR CARE

HEDLUND CHIROPRACTIC P.A.

Get back into life.

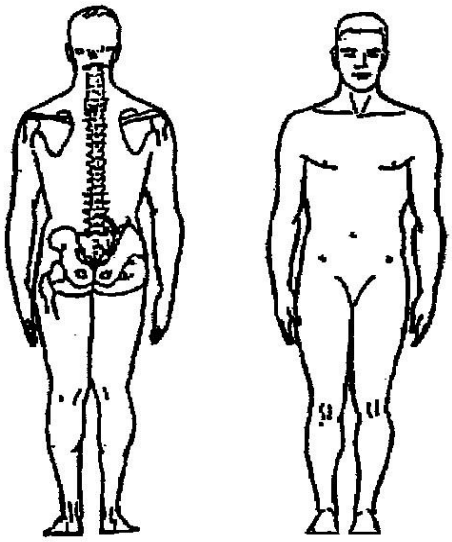
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the Chiropractic Assistant. (PLEASE PRINT.)

Today's Date _____

Name _____ Cell Phone _____ Home Phone _____
Work Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____
Your Employer _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____

Name of Spouse or Parent _____ Their Birth date _____
Spouse Employed By _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Work Phone # _____ Cell Phone _____

What are your major complaints that you are experiencing? Please start with the complaint that is most significant first.	Rate pain and discomfort between 1-10 1 = Minimal 10 = Severe	Check off the types of Complaint							Frequency	
		Radiating	Sharp	Dull / Achy	Tingling	Numbness	Burning	Tight	Constant	Intermittent



Use the figures to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.

Is your condition due to an accident? Yes ____ No ____

Date of accident? _____

Type of accident? Auto ____ Work / On the job ____

At home ____ Other _____