APPLICATION FOR TREATMENT

Name: ______________________________ Date: ______________

Doctor referred to: ____________________ Referred by: ____________________

1. REASON FOR VISIT:

List your chief complaint:

____

____

____

When did this episode begin? ______________________

How did it occur? Gradually Suddenly

Describe: ______________________________

____

Is it: Worse Better Intermittent Constant Daily

Have you had this or similar problems in the past? Yes No

If yes, when? ______________________________

When is it worse? AM PM Nighttime

With what does it interfere? Work Sleep Daily routine

Other: ______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Do you have pain/numbness in the arms, legs, hands or feet?

Yes No Where and what type? ____________________

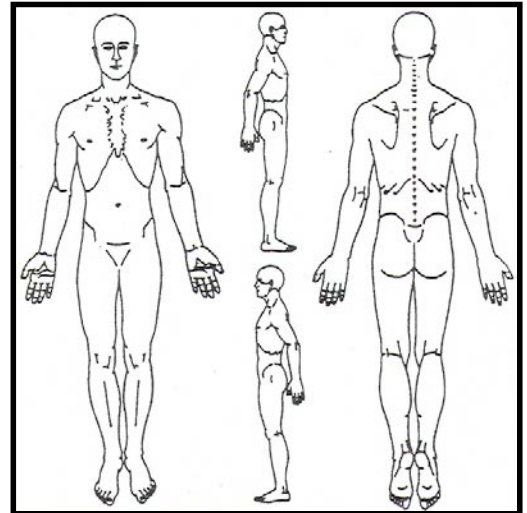
Have you seen any other doctors for this problem? Yes No

If yes, doctor's name: ______________________________

(IN OFFICE)

DRAW PAIN AREAS BELOW 🡇

XXX = PAIN // = NUMBNESS



What type of physician? Chiropractic Medical Other Most recent visit date: ______________

What did they recommend? ______________________________

On a scale of 0 to 10, with 10 = extreme pain, and 0 = no pain, rate your average pain level: ______________

2. PAST HEALTH HISTORY:

Drugs you now take: Pain killers Muscle relaxers Blood pressure Birth control Other: ________

List all surgeries you have had and when: ______________________________

____

Prior Injuries (please circle location and describe type of injury):

Shoulder / Arm / Elbow / Wrist / Hand / Finger / Hip / Leg / Knee / Ankle / Foot / Toe

Head / Spine / Pelvis

Describe injuries: ______________________________

____

Which (if any) of the above injuries still bother you? ______________________________

____

Have you ever experienced loss of consciousness? If so, describe: ______________________________

____

Last auto accident: Past year Past five years Over five years Never

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3. FAMILY HEALTH HISTORY

Many health problems have familial tendencies. Information about family members will give us a better picture of your total health.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

4. YOUR HEALTH HISTORY

C = Current, P = Past

General
- C P Allergy
- C P Convulsions
- C P Dizziness
- C P Fainting
- C P Headache

Muscle & Joint
- C P Arthritis
- C P Bursitis
- C P Low back pain
- C P Neck pain/stiffness
- C P Pain between shoulders
- C P Spinal Curvature

Eyes, Ears, Nose & Throat
- C P Deafness
- C P Earache
- C P Failing Vision
- C P Nosebleeds
- C P Sinus infections
- C P Strep throat

General-Intestinal
- C P Colon trouble
- C P Constipation
- C P Diarrhea
- C P Gall Bladder trouble
- C P Hemorrhoids
- C P Hernia
- C P Liver trouble
- C P Nausea

Respiratory
- C P Asthma
- C P Chest Pain
- C P Chronic cough
- C P Spitting up blood

Pain or numbness in
- C P Shoulders/Arms
- C P Elbows/Hands
- C P Hips/Legs
- C P Ankles/Knees/Feet

Skin problems
- C P Bruise easily
- C P Hives or allergy
- C P Skin rash

Other
- C P Diabetes
- C P Alcoholism
- C P Anemia
- C P Cancer
- C P Measles
- C P Stroke
- C P Rheumatic fever
- C P Sex trans disease
- C P Gout
- C P Mumps
- C P Polio

Cardio-Vascular
- C P Hardening of arteries
- C P High blood pressure
- C P Low blood pressure
- C P Rapid/slow heart beat
- C P Swelling of ankles

Genital-Urinary
- C P Bed-wetting
- C P Frequent urination flow
- C P Kidney infection
- C P Painful urination
- C P Prostate trouble

For Women Only
- C P Cramps or backaches
- C P Excessive menstrual
- C P Irregular cycle
- C P Lumps in breast
- C P Post-menopausal

Psycho-Social
- C P Depression
- C P Anxiety
- C P Sleep disturbances
- C P Chronic fatigue
- C P Divorce
- C P Death
- C P Family problems
- C P Economic
- C P Drugs/Alcohol
- C P Change in job status
- C P Work problems

Check the appropriate box below:

Meals skipped:	Coffee-Daily	Alcoholic beverages		Personal satisfaction w/diet
Daily no._______	1-2 daily	1-2 daily	1-2 weekly	Highly satisfied
	3-4 daily	3-4 daily	3-4 weekly	Satisfied
Weekly no______	More	More		Highly unsatisfied

IN CASE OF EMERGENCY: (Name of friend or relative not living at home)

Name: ____ Relationship: _______________________

Address:____Phone#:______________________

Fees are payable at the time x-rays, examination, and treatment(s) are received unless other arrangements are made in advance. X-rays remain the property of this clinic. I understand the above and hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of any combination of radiographs, manipulation (inclusive of my spine and extremities), therapy, rehabilitative exercises and acupuncture.

Patient Name (Legal Guardian):____________________________ Date:_____________________

Assignment of Benefits Form

Financial Responsibility- All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits- I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Daniel Bockmann medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information- I hereby authorize Dr. Daniel Bockmann to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Daniel Bockmann on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. **Appointment's cancelled or re-scheduled without a 24 hour notice will be subject to a $25.00 charge.**

Patient/Responsible Party Signature: ________________________________ Date: ________________________________

Consent and Authorization for Electronic Communication (E-Mail)

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my healthcare provider. I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information. I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered. In consideration of my desire to use electronic communication as supplement to in-person office visits with my provider, I hereby consent to electronic communication via non-secure e-mail services. I understand that I may revoke my consent to communicate electronically at any time by notifying Dr. Daniel Bockmann in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT NAME (PRINT) ____

PATIENT SIGNATURE ____ DATE: _________________

PATIENT INFORMATION:

First Name: ______________________________ M.I. _________ Last Name: ____________________________________

Address: ____

City: _________________________ State: _________ Zip: _______________ Phone: (________) _________________

Sex: M F DOB: _____/______/______ Age: _____ Marital Status: M S D Email: ___________________

Social Security # ___________________________________ Cell: (_________) _______________________

EMPLOYER:

Name: ____ Occupation: ____

Address: ____

City: ______________________ State: _____________ Zip: ________________ Phone: (________) _______________

INSURANCE CARRIER:

____

Address: ____

City: _________________________ State: ____________ Zip: _____________ Phone: (________) _______________

Policy#: ____ Group#:____

Insured First Name: ______________________________ M.I. ______ Last Name: ________________________________

Sex: M F DOB: _______/________/_________ SS#: ___________-_________-___________

IS THIS INJURY A(N): ☐ Auto Accident ☐ On-the-job Injury ☐ Other

Date of injury: ________/_________/_______________ Time of Injury: _________:_________ AM PM

Who referred you to our office? ____

Appointment Date: __________/__________/__________ Appointment Time: ___________:_________ AM PM

Chief Complaint: ____

____

____

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