Horning
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Center, P.A.

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APPLICATION FOR TREATMENT

Date:_____

Please check the type of care desired: _____Temporary Relief _____Lasting Correction

_____Check here if you want the Doctor to select the type of care he feels is best for you

Name:_____Date of Birth_____

Address:_____City:_____ State_____Zip_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

E-mail address:_____

Check if you are : ___Married ___Single ___Widowed ___Divorced ___Separated

Name of husband or wife:_____Ages of Children:_____

Where are you or husband/wife employed?_____

Referred to our office by:_____

Who is responsible for your bill? ____Self ____Insurance ____Other_____

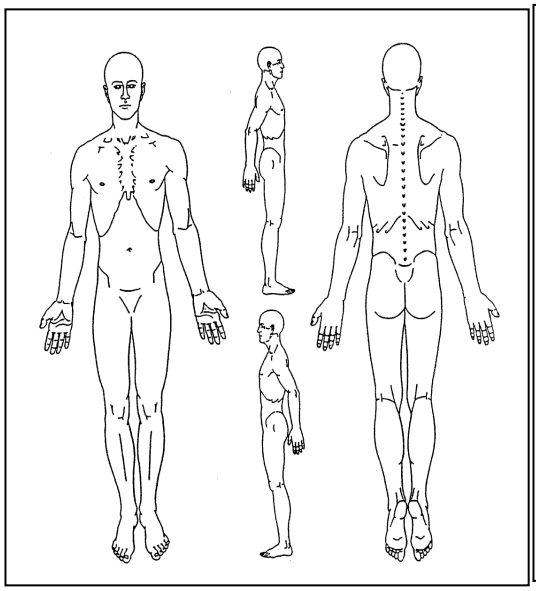
How Payment will be made:
_____Cash _____Health Insurance _____Check _____Credit Card

Name of Insurance Company :_____

Is your visit a result of an auto or work related accident? ☐ Yes ☐ No If yes, what was the date of your accident._____

If you are in pain, please mark the exact location of your pain on the diagram below.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe your major complaint)

How did this condition develop? (What caused it? How did it start?)_____
_____

When was the very first time you were aware of this problem?_____

Have you ever had this problem or similar problem before? If yes, please explain:_____
_____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results?_____
_____

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

Is there anything you do that makes your condition worse?_____
_____

How has this condition affected your:

A. Home life?_____

B. Occupational life? _____

C. Recreational life? _____

D. Rest and sleep life? _____

Have you ever been in an automobile accident? _____Past year _____Past 5 years _____Over 5 years _____Never

ANY ACCIDENTS, FALLS, ETC. THAT MIGHT HAVE CAUSED YOUR PROBLEM? _____
_____

ANY MEDICAL DIAGNOSIS FOR YOUR COMPLAINT?_____
_____

What surgery has been done? _____
_____

Drugs you now take: ___Nerve Pills ____Pain Killers ___Muscle Relaxers ____ Anti-Depressants ____Tranquilizers ____Insulin ____Birth Control Other (please list)_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name:_____
Dates consulted:_____ For what problem? _____

Fees are payable at the time x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's signature: _____

Social Security No. _____ Date: _____