One Goal Wellness

PATIENT APPLICATION FOR TREATMENT

Name: _____ Date of birth: _____ Male Female

Address: _____ City: _____ State: ___ Zip: _____

SS# (if VA): _____ Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Email: _____ Emergency contact: _____ Phone: (____)_____

Employer: _____ Occupation: _____

Number of children: _____ Their ages: _____

Do you have health insurance?: Yes No Job disability within the last 12 months?: Yes No

Have you ever had chiropractic care?: Yes No If yes, how long ago?: _____

Who referred you to the office?: _____

Is your visit the result of an auto accident? Yes No

Allergies?: _____

Do you suffer from, been diagnosed as having, or currently have any of the following? (Circle Y or N for each)

Y N High Blood Pressure	Y N Low Blood Pressure	Y N Type 1 Diabetes	Y N Type 2 Diabetes
Y N Congenital Disease	Y N HIV Positive	Y N Circulatory Problems	Y N Cold Hands/Feet
Y N *Broken/ Fractured Bones	Y N *Osteoarthritis	Y N *Rheumatoid Arthritis	Y N Hand Tremors
Y N Pacemaker	Y N Tumors	Y N Insomnia	Y N *Cancer
Y N Seizures/Convulsions	Y N Dizziness/Fainting	Y N Loss of Memory	Y N Strokes
Y N Gall Bladder Problems	Y N Loss of Bladder Control		

*Explanation: _____

Name of Medication/Vitamin	Dosage	Frequency	Who Prescribed	Purpose for Taking

One Goal Wellness is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Your signature below acknowledges that you have been given an opportunity to read the Notice of Privacy Practices. You are also agreeing to payment and health care operations as the Notice of Privacy Practices.

Patient Signature: _____ Date: _____