

# Application for Treatment

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Married  Single  Divorced  Other Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

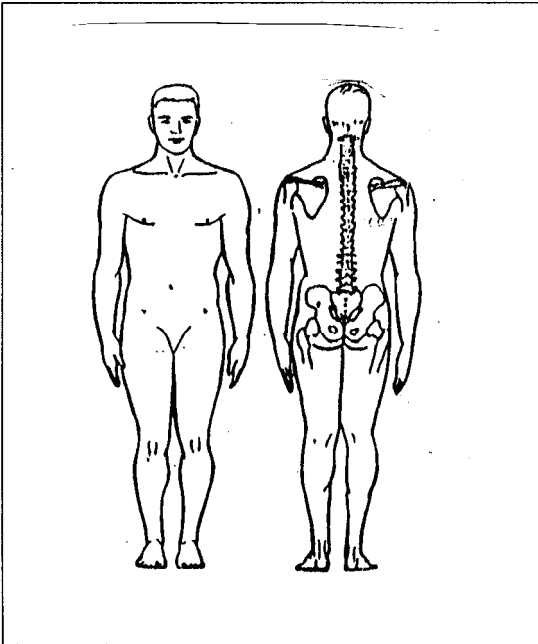
Name of husband/wife \_\_\_\_\_ Ages of Children \_\_\_\_\_

Place of Your Employment \_\_\_\_\_ email: \_\_\_\_\_

How will payment be made?  Cash  Check  Credit Card  Insurance

Please mark the exact location of your pain on the diagram below, describing the frequency, as well as any activity that brings on or aggravates the pain. Example, dull, sharp, constant, off and on, etc.

## Major Complaint

How did this condition develop?

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Briefly describe any treatment you have had for this condition. \_\_\_\_\_

Have you ever been in an automobile accident?  Past Year  Past 5 Years  Over 5 Years  Never

Any accidents or falls that might have caused your problem? \_\_\_\_\_

Drugs you take:  Muscle Relaxers  Pain Killers  Tranquilizers  Insulin  High Blood Pressure  Cholesterol

Other \_\_\_\_\_ Are you pregnant?  Yes  No

*Fees are payable at the time service is rendered unless other arrangements are made in advance. I hereby authorize and request any person to whom this authorization is presented to furnish Back & Neck Care Center, LLC any x-rays, records or reports concerning my illness. I also authorize Back & Neck Care Center, LLC to furnish information concerning my present illness or injury and direct the insurer to pay without equivocation, directly to Back & Neck Care Center, LLC any and all benefits due them as a result of this claim. I am also aware that I am personally responsible for charges and/or balances not covered by my insurance. I hereby state and agree that a photocopy of this document will be valid and binding on all parties. I hereby acknowledge notification of the Notice of Privacy Practices for Dr. Miglis.*

**Patient Signature** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Date** \_\_\_\_\_

**MEDICAL HISTORY FORM**  
Mitchell F. Miglis, DC, Cert MDT

**Past Medical History and Review of Systems:**

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Please check (X) the box next to any illness or problems that apply to you:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Heart attack                 | <input type="checkbox"/> Blood clots       | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> HIV                |
| <input type="checkbox"/> Heart trouble                | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Bowel disorders    |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Birth defects     | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Sickle cell        |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Bladder disorders | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Cough              |
| <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Gout              | <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Other; Please describe _____ |  |  |   |

**Medications:**

Please list medications you are currently taking. If name unknown, list reason for taking:

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**Social History:**

Single  Married  Divorced  Widowed

Work status:  Employed (Doing what? \_\_\_\_\_)  Unemployed  Disabled  
 Retired  Student

Smoker  Yes  No Alcohol use  Yes  No Other drug use \_\_\_\_\_

**Family History:**

Please check (X) the box next to any disease or condition diagnosed in your blood relatives:

Arthritis  Heart disease  Rheumatoid arthritis  Diabetes  Bleeding problems  
 Gout  Cancer  Back or neck problems  Other: \_\_\_\_\_

**Have you recently had any of the following? Check (X) if yes.**

- Fever, chills, night sweats
- Unexplained weight loss
- Any recent infection (for example, urinary tract infection, etc.)
- Prolonged steroid use
- Intravenous (IV) drug use
- Pain which awakens at night
- Absence of or unusual sensation in the area around the anus.
- Bowel or bladder dysfunction (urinary retention, incontinence, changes in frequency)
- Any history of recent trauma or injury not reported on your Application for Treatment?

Any other comments or problems you would like to mention? \_\_\_\_\_

**NAME (Please PRINT/then SIGN)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Dr. Review: \_\_\_\_\_