Robert Ehle, D.C., P.A.

Case No. _____

Fin. Class _____

PATIENT APPLICATION

Full Name _____ Date of Birth _____ SS No. _____

Address _____ City _____ State _____ Zip _____ ☐ Male ☐ Female

Home Ph _____ Cell Ph _____ Work Ph_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other Language: ☐ English ☐ Spanish ☐ _____

E-mail addr: _____ Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Nat Am ☐ Other

Place of Employment _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____

Name & Ages of Children _____

Who may we thank for referring you? ☐ Friend's name _____ ☐ Yellow pages ☐ _____

Confidential Communications Preference: ☐ Home Ph ☐ Cell Ph ☐ Work Ph ☐ Email ☐ Mailing Address

---

Payment will be made by: ☐ Health Insurance ☐ Worker's Compensation ☐ Auto Insurance ☐ Medicare ☐ Cash / Credit Card

Are you covered by more than one insurance company? ☐ Yes ☐ No

---

REASON FOR VISIT

_____

_____

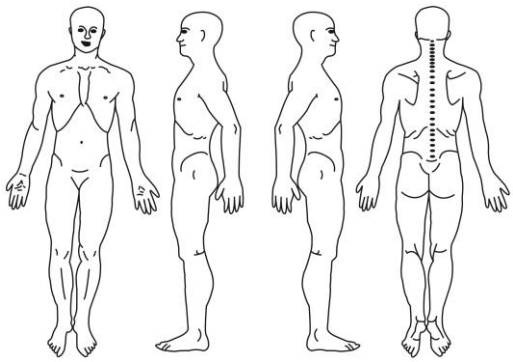
_____

_____

_____

_____

Please Mark Areas of Pain / Symptoms



SYMPTOMS DEVELOPED FROM: ☐ Job Injury ☐ Auto Accident ☐ Other Injury ☐ Illness ☐ Unknown cause

Have you had this condition before? ☐ Yes ☐ No If yes, explain _____

Give names of doctors previously seen for present condition _____

Have you consulted a Chiropractic Physician in the past? ☐ Yes ☐ No If yes, doctor's name _____

Results of previous chiropractic care: ☐ Good ☐ Bad ☐ Indifferent

Have you ever been in an auto accident, even a fender bender? ☐ Yes ☐ No If yes, how many? _____

Date consulted _____ For what reason _____

Whom to contact in case of emergency: Name _____ Phone No. _____

Relationship _____ Address _____

I clearly understand and agree that all services rendered to me, my child or ward, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care and treatment, any fees for professional services rendered to me, my child or ward, will be immediately due and payable.

I authorize the performance of diagnostic X-ray examination of myself, my child or ward which the above doctor may consider necessary or advisable in the course of my examination and treatment. X-rays remain the property of this clinic.

I authorize the release of any medical information necessary to process my claims and to any other provider involved in my care. I also authorize payment of medical benefits to Robert Ehle, D.C., P.A. for services rendered.

I have reviewed the “Notice of Privacy Practices” for myself / this patient.

Patient/ParentSignature_____ Date_____

Robert Ehle, D.C., P.A. Patient Name _____ Date _____

REVIEW OF SYSTEMS: Please check all symptoms you have **currently or** have had during the **last 6 months**.

BLOOD / LYMPH
- ☐ Bleed easy
- ☐ Bruise easy
- ☐ Glands swollen
- ☐ Nose bleeds

CARDIO-VASCULAR
- ☐ Ankle swelling
- ☐ Calf pain
- ☐ Chest pain / pressure
- ☐ Blood pressure, high
- ☐ Blood pressure, low
- ☐ Left neck / arm pain
- ☐ Palpitations
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Short of breath w/exertion
- ☐ Short of breath awakening

CONSTITUTIONAL
- ☐ Anxiety
- ☐ Chills
- ☐ Confused / Disoriented
- ☐ Depression
- ☐ Fatigue
- ☐ Fever
- ☐ Hayfever
- ☐ Insomnia
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight loss

MUSCULO-SKELETAL
- ☐ Arthritis
- ☐ Atrophy Muscle
- ☐ Bone Infection
- ☐ Cramps
- ☐ Disc Herniation
- ☐ Fracture
- ☐ Injury / Trauma
- ☐ Muscle Wasting
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Sprain

NEUROLOGICAL
- ☐ Convulsions
- ☐ Faint / Dizziness
- ☐ Headache
- ☐ Off balance / Unsteady
- ☐ Recent falls
- ☐ Tremors

SKIN / INTEGUMENT
- ☐ Boils
- ☐ Eczema
- ☐ Fungus
- ☐ Hives
- ☐ Rash

PERSONAL HEALTH: Check any of the following conditions you have or have had.

- ☐ .AIDS / HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Aneurysm
- ☐ Angina
- ☐ Appendicitis
- ☐ Asthma
- ☐ BP, Low
- ☐ BP, High
- ☐ Cancer
- ☐ Colitis
- ☐ Concussion
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Edema
- ☐ Emphysema
- ☐ Encephalitis
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepititis
- ☐ Hernia
- ☐ Herpes
- ☐ Hodgkin's Disease
- ☐ Hypoglycemia
- ☐ Irritable Bowel
- ☐ Leukemia
- ☐ Lyme Disease
- ☐ Menningitis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Myosthenia Gravis
- ☐ Osgood Schlatters
- ☐ Osteomyelitis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Systemic Lupus
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Surgeries you have had: _____

_____

FAMILY HEALTH

	Cancer	Heart Disease	Stroke	Alzheimers/ Dementia	Diabetes	Lung Disease	Osteo-porosis	Substance Abuse
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Siblings								

SOCIAL HEALTH

Smoking	☐ Never	☐ Former	☐ Current

	None	Light	Moderate	Frequent
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Current MEDICATIONS: ☐ None Or

Name	Dosage	Prescribing Provider

ALLERGIES to medication: ☐ None Or _____

_____

_____

_____