All Natural Chiropractic
405 W. Main Street
Genoa, IL 60135

Dr. Mark Jacobs
(815)784-4455

Patient Application For Treatment

Date: _____/_____/_____
Name_____ Date of Birth ___/____/____ Social Security #_____/_____/_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Cell_____ Email:_____
Occupation_____ Employer_____ Work Phone_____
Employer's Address _____
Spouse's Name_____
Parent's/Guardian's Name (if applicable)_____ Parent's/Guardian Social Security_____/_____/_____
Referred by: Phone Book_____ Family/ Friend (name)_____ Other_____
(Name of Directory) Please List

Primary Insured Information
Insured's Name_____ Date of Birth_____/_____/_____ Social Security _____/_____/_____
Relationship to patient:_____ Type of Insurance_____

When did you first start to feel pain (Need actual date)_____

On a number scale of 1-10 (10 is the worst), rate the pain you are currently experiencing in your:

Head/Sinus'_____ Neck_____ Jaw_____ Midback_____ Low Back_____ Hip_____ Wrist_____
Elbow_____ Shoulder_____ Knee_____ Ankle_____ Foot_____ Difficulty Breathing_____ Other_____

Type of Pain: Sharp_____ Dull_____ Stabbing_____ Burning_____

Seen another physician for this condition? Yes_____ No_____ **Physician's Name**_____ **Phone**_____
X-rays/MRI's for this condition within last year? Yes_____ No_____ Who may we contact for them_____
Lost time from work/school for this condition? Yes_____ No_____ Total # Days_____

Do you have/have you had any of the following? **Check Mark** indicates Yes

____ Broken Bones	____Osteoarthritis	_____Rheumatoid Arthritis	____Tumors
____ Diabetes	____Epilepsy	_____High/Low Blood Pressure	____Stroke
_____Respiratory/ Asthma	____Gall Bladder	_____Cancer	_____Coughing Blood
_____Heart/Pacemaker	____Excessive Bleeding	_____ Neurological disorder	_____Circulatory Disorders
_____HIV	____Seizure	_____Eating Disorder	_____Drug Addiction
_____Head Injury	____Depression	_____Alcoholism	_____ Osteoporosis
_____ Gastric Bipass	____ Hemorrhoids	_____	
_____Congenital Disease (list type)_____		Other:_____	

Do you drink diet soda Y N Do you chew gum Y N Artificial Sweeteners Y N
Are you pregnant **Y** **N** Birth Control? **Y** **N**
Are you a stomach sleeper? **Y** **N** Do you sit in a recliner **Y** **N**

Is this condition work related? Y N Is this condition accident related Y N
(We must know this at the time of your visit. The doctor cannot legally change his notes at a later date to reflect work comp or personal injury)

1) **I hereby give All Natural Chiropractic CONSENT to TREAT me/my minor child.**

2) **I understand that all records established by this office are the sole property of Dr. Jacobs. Copies will be made upon written consent to the doctor**.

3) **I authorize release of any medical records or other information necessary to process my insurance claims.**

4) **I understand that I am responsible for payment of my bill even if my health insurance/work comp or auto insurance does not pay.**

5) **I understand all co-pays, deductibles & cash payments are due at time of service.**

_____ **Date ____/____/_____**

Patient/Guardian Signature