

Please complete the following 2 pages.

**You can postal mail the completed
application to:**

**Physicians First, Inc.
1438 S.O.M. Center Road
Mayfield Heights, OH 44124
Attn: Application for Treatment**

**Or you can fax it back to us at:
440.461.5548**

Thank You!

APPLICATION FOR TREATMENT

Confidential Patient Information

PATIENT INFORMATION	Your Name _____	Date of Birth _____	Age _____
	Address _____	Sex _____	
	City, State, Zip _____	Social Security # _____	
	Home Phone _____	Work Phone _____	
	Cell Phone (Opt.) _____	No. of Children _____	
	Your Occupation _____	Employer Name _____	
	Employer Address _____	City, State, Zip _____	
	Spouse's Name _____	Work Phone _____	
	Nearest Relative _____	Phone _____	

PRESENT COMPLAINT	Describe Your Problem _____	
	Doctors Seen for This Problem _____	Work Days Missed _____
	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	How Many Days? _____

MEDICAL HISTORY	<input type="checkbox"/> Polio	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Numbness	<input type="checkbox"/> Nervousness	<input type="checkbox"/> German Measles	<input type="checkbox"/> High Blood Pressure
	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Backaches	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Muscular Dystrophy
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Concussion	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Multiple Sclerosis	
	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Digestive Disorders	

PREVIOUS CARE	Previous Surgeries _____	When? _____
	Have you seen a physician for any reason or condition in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Describe Reason or Condition _____	
	Allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Kind? _____
	Currently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Kind? _____
	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Period? _____

INSURANCE INFORMATION	Insured Name _____	Phone _____
	Insured Address _____	
	Insurance 1 Name _____	Policy No. _____
	Insurance 1 Address _____	Group No. _____
	Insurance 2 Name _____	Policy No. _____
	Insurance 2 Address _____	Group No. _____
	Spouse's Insurance Name _____	Policy No. _____
	Address _____	Group No. _____
Workers' Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group No. _____	
Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare No. _____	

PATIENT AGREEMENT	I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that Physicians First, Inc./Gallucci Chiropractic Clinic is not a direct party to the insurance carrier or other third party. As such, I understand and acknowledge that I am directly and fully responsible for all bills submitted by Physicians First, Inc./Gallucci Chiropractic Clinic for health care services rendered to me. I agree to furnish Physicians First, Inc./Gallucci Chiropractic Clinic all Explanation of Benefit forms and other information as needed to assist them with collections for the services rendered.	
	Patient (or Responsible Party) Signature _____	Date _____

PLEASE TELL US	How did you decide to come to our clinic?	
	Where you referred by someone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who? _____
	Where you referred to a certain doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, who? _____
	Family/Primary Care Doctor _____	Location _____
	May we share information regarding your condition and/or treatment with this doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	E-mail Address _____	May we send you healthcare information? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wish to have a third person or chaperon present during your exam and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is your visit due to an accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete the other side of this form.</i>		

ACCIDENT/INJURY REPORT

GENERAL INFORMATION	Day and Date of Accident/Injury _____	Time of Accident/Injury _____	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Type of Accident/Injury <input type="checkbox"/> Work Related <input type="checkbox"/> Traffic <input type="checkbox"/> Other	Number of Days Missed From Work _____	

WORK-RELATED ACCIDENT	Employer _____	Type of Business _____
	Were any equipment, machinery, or other objects related to the accident/injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, please describe _____	
	Was accident reported to a Supervisor and/or Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a Workers' Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the accident/injury, including cause(s) and surrounding circumstances _____		

TRAFFIC ACCIDENT	What type of vehicle was involved in the accident? <input type="checkbox"/> Truck <input type="checkbox"/> Car <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other	Were you a <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian?	If a passenger, where? <input type="checkbox"/> Front Seat <input type="checkbox"/> Back Seat <input type="checkbox"/> Other	
	Was your vehicle moving at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did your vehicle hit other vehicle(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	MPH? _____	Where? _____
	Did other vehicle(s) hit your vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Approximately how much damage (in dollars) was done to your vehicle? \$ _____	Was this accident reported to the Police? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Were traffic citations issued? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom? _____	Describe the accident/injury, including cause(s) and surrounding circumstances _____	

PRESENT COMPLAINT	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Excess Perspiration	<input type="checkbox"/> Neck Restricted	
	<input type="checkbox"/> Tension	<input type="checkbox"/> Headache	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Feet/Hands Cold	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Low-back Pain/Stiff	
	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Face Pale	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Ears Buzz/Ring	<input type="checkbox"/> Upper-back Pain/Stiff	
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Extreme Fatigue	<input type="checkbox"/> Equilibrium Problem	<input type="checkbox"/> Pins & Needles	
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Mental Dullness	<input type="checkbox"/> Head Seems Heavy	<input type="checkbox"/> Shoulders Tired	
	<input type="checkbox"/> Tremors	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Digestive Trouble	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Extremity Numbness	
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Eyes Light Sensitive	<input type="checkbox"/> Swollen Areas:	
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Mid-back Pain/Stiff		
	<input type="checkbox"/> Difficulty in excessive: <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Riding <input type="checkbox"/> Bending						
	<input type="checkbox"/> Neck and low back pain and stiffness upon rising						
<input type="checkbox"/> Pain radiating into: <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Arm <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Hips <input type="checkbox"/> Skull							
<input type="checkbox"/> Difficulty in Lifting: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Only if Repetitive							
Did you require post-accident hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, where? _____			
Have you had similar accidents/injuries before? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<input type="checkbox"/> Any symptoms in addition to, or other than those checked above? _____							

INSURANCE INFORMATION	Insurance Company of Responsible Party _____	Claim Number _____
	Have you been contacted by an insurance adjuster or representative about claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you have an attorney advising you in this case? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, Attorney Name _____	
	Attorney Address _____	
Attorney Phone _____		

PATIENT SIGNATURE	I hereby attest that all of the above is true and accurate to the best of my knowledge and ability to recall the accident/injury.	
	Patient Signature _____	Date _____