APPLICATION FOR ADMISSION

DaySpring Family Wellness Center

Name _____ Date _____ Birthdate _____ Age ____

Address _____City _____ State _____ Zip _____

Home Phone _____Cell _____Work _____ □ M □F

Significant Other's Name _____

Names and Ages of Children_____

Your Employer _____Type of Work_____

Social Security # _____ E-mail Address _____

Emergency Contact Person _____Phone _____

Name of Medical Doctors:_____

If you have had an MRI, list when and where it was taken: _____

How did you hear about DaySpring? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I understand that I am responsible for all bills incurred for services.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient:_____
- Information on the privacy of your Personal Health Information is available from the doctor.
- For my balance, my preferred method of payment is: □Cash □Check

Signature _____ Date _____

REASON FOR SEEKING CARE

What is the problem that you are seeking care for?_____

How long has this been an issue?_____

Does your condition affect: □sleep □work □daily routine □sitting □driving

Is it worse in the: □morning □mid-day □evening □doesn't matter

Is the pain: □dull or □sharp

How often are you aware of it? □occasionally □ 50% of the time □75% of the time □constantly

What makes you feel better? _____

What makes you feel worse? _____

Previous treatments □shots: when _____ □pain pills/relaxants: when _____

□therapy: when _____ □chiropractic: when _____

□surgery: when _____ □other: _____ when _____

What do you think the problem is? _____

_____

Do you consider your problem: □mild □moderate □severe □extreme

What activities bother you because of your problem:

_____

Have you lost time from work? □yes □no

Have you lost time from family/friends? □yes □no

What are you hoping we can do for you?

_____

(X) Mark Areas of Concern