



# VITALITY CHIROPRACTIC CENTER

Corey T. Ebbin, D.C.

410 Bellevue Way SE Ste. 202 / Bellevue, WA 98004

(425) 378-1800 ph. (425) 462-1802 fax

## Treatment Application

Please check the type of care desired:  Temporary Relief  Lasting Correction  
 Check here if you want the Doctor to recommend the best type of care for you.

Date: \_\_\_\_\_

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

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check if you are:  Married  Partnered  Single Social Security No. \_\_\_\_\_

How did you hear about our office \_\_\_\_\_

Name of Husband or Wife \_\_\_\_\_ Ages of Children \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone number \_\_\_\_\_

Who is responsible for your bill?  Self  Spouse  Insurance  Other \_\_\_\_\_

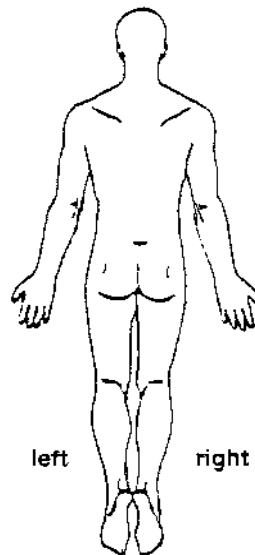
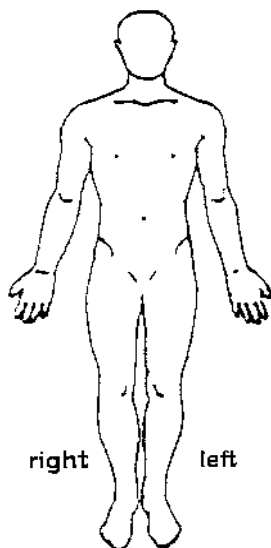
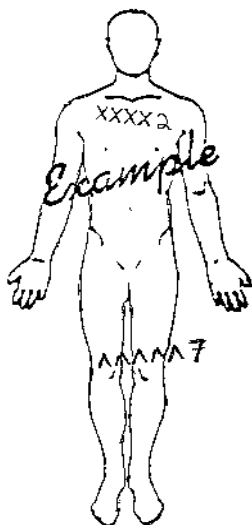
Type of Insurance: Health Insurance \_\_\_\_\_ Workers' Comp. \_\_\_\_\_

Automobile Insurance \_\_\_\_\_ Date of accident \_\_\_\_\_

If you are in pain, please mark the exact location of your pain on the diagram below.

Indicate your level of pain using a scale of 1 (minor discomfort) to 10 (extreme pain):

Numbness: Pins & Needles: Burning: Aching: Stabbing:  
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How did this condition develop? (What caused it? How did it start?) \_\_\_\_\_

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

Have you ever had this problem or a similar problem before? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever received any treatment for this condition? If yes, where and when, and what were you results? \_\_\_\_\_  
\_\_\_\_\_

Has this problem been getting better, worse, or staying the same? \_\_\_\_\_  
\_\_\_\_\_

Is there anything you do that makes your condition worse? \_\_\_\_\_  
\_\_\_\_\_

How has this condition affected your life?  
Home life \_\_\_\_\_  
Occupational life \_\_\_\_\_  
Recreational life \_\_\_\_\_  
Rest and Sleep life \_\_\_\_\_

Have you ever been in an automobile accident?  Past year  Past 5 years  Over 5 years  Never  
ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM \_\_\_\_\_  
\_\_\_\_\_

What surgery has been done? \_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?  Yes  No  
DRUGS YOU TAKE NOW:  Nerve Pills  Pain Killers  Muscle Relaxers  Pep Pills  Tranquillizers  
 Birth Control  Other (please list) \_\_\_\_\_

ANY CHIROPRACTORS CONSULTED IN THE PAST? Name: \_\_\_\_\_  
Dates consulted \_\_\_\_\_ For what problem? \_\_\_\_\_  
Any additional information you would like us to know \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fees are payable at the time X-rays, examinations, and treatment are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.**

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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CONSENT TO TREATMENT OF MINOR CHILD

I, \_\_\_\_\_ hereby authorize Dr. Corey T. Ebbin, D.C.  
to administer treatment as he deems necessary to

\_\_\_\_\_  
(SON)

\_\_\_\_\_  
(DAUGHTER)

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_