O'FALLON CLINIC

APPLICATION FOR TREATMENT

Name _____ ☐ M ☐ F Date _____

Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Employer _____ Job Title _____

Job Description _____

Check if you are ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

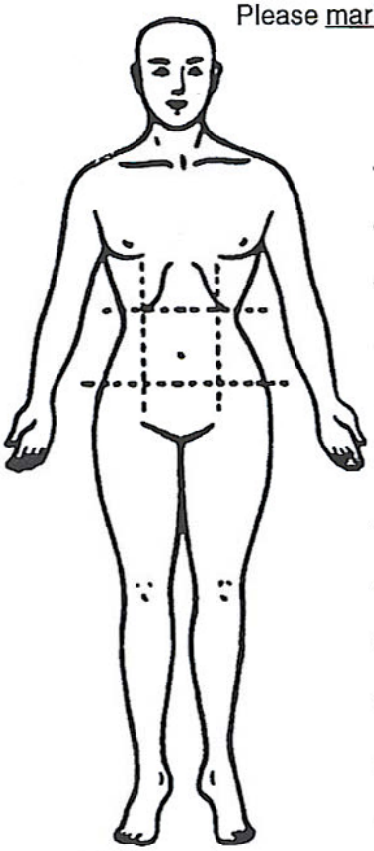
Name of Husband or Wife: _____ Referred by _____

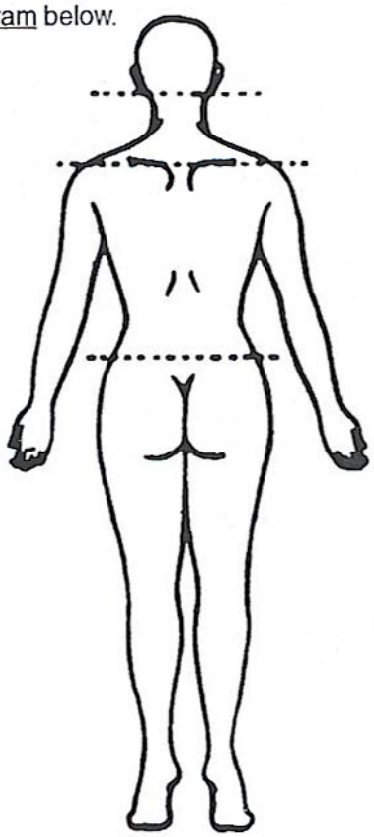
How payment will be made:

☐ Cash ☐ Check ☐ Credit Card ☐ Ins.

Type of Insurance: ☐ Health Ins. ☐ Workers' Comp. ☐ Automobile Ins. Policy

Please mark the exact location of your major complaint using the diagram below.
Please describe your major complaint





When did this condition develop? _____

How did this condition develop? (What caused it?) _____

Have you ever had this problem or similar problem before? If yes, please explain _____

(OVER)