

Pamala A. Mitchell D.C.  
**ACCIDENT & SPORTS INJURY CLINIC**  
7623 Tezel Road  
San Antonio, Texas 78250  
PH: 210-630-5133 Fax: 210-520-0891  
**APPLICATION FOR TREATMENT**

NAME (Print): \_\_\_\_\_ DATE: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ M / F

DATE OF BIRTH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ AGE: \_\_\_\_ Ht.: \_\_\_\_ ' \_\_\_\_ " Wt.: \_\_\_\_ lbs.

ADDRESS: \_\_\_\_\_ SOC. SEC. No#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

CITY:  San Antonio \_\_\_\_\_ STATE:  Texas \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ EMAIL: \_\_\_\_\_ @ \_\_\_\_\_ .COM

CELL #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ HOME #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  None  TEXT OK

CHECK ONE:  MARRIED  SINGLE  WIDOWED  DIVORCED  SEPARATED

REFERRED BY: \_\_\_\_\_

YOUR HEALTH INSURANCE: \_\_\_\_\_ MEMBER ID#: \_\_\_\_\_  NONE

OCCUPATION: \_\_\_\_\_ DAYS OFF: **S M T W TH F S**

WORK HOURS: \_\_\_\_ AM PM to \_\_\_\_ AM PM EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  San Antonio \_\_\_\_\_

Texas \_\_\_\_\_ ZIP Code: \_\_\_\_\_

1. In Detail please explain what your complaint is and how you got hurt:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Give date you developed this condition developed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Have you had this condition or similar condition before?  Yes  No If yes, please explain in detail: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you received treatment for this condition before?  Yes  No If yes, please list doctor's name, address, and phone no.#: \_\_\_\_\_

\_\_\_\_\_

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## APPLICATION FOR TREATMENT

5. Has there been a medical diagnosis for this condition?  Yes  No If yes, please explain in detail:

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6. Have you had surgery for this condition?  Yes  No When \_\_\_\_/\_\_\_\_/\_\_\_\_

Results  Poor  Fair  Good

7. Has this condition gotten:  Worse  Stayed the Same  Better

Describe: \_\_\_\_\_

8. Is there anything that makes this condition worse?  Yes  No If yes, please explain:

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9. is there anything that makes this condition better?  Yes  No If yes, please explain:

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10. Have you been in a automobile accident?  Past year  Past 5 yrs.  Over 5 yrs.  Never

11. Has this condition affected your:  Home life  Work  Recreation  Sleep  Other \_\_\_\_\_

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12. Medications you currently take:  Anti-Depressants: \_\_\_\_\_

Pain Medications: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_

Blood Sugar: \_\_\_\_\_

Energy Pills: \_\_\_\_\_

Pain Killers: \_\_\_\_\_

Birth Control/Hormones: \_\_\_\_\_

Sedatives: \_\_\_\_\_

Other: \_\_\_\_\_  None

Fees are payable at the time when examination and treatments are received unless other arrangements are made in advance. X-Rays remain the property of Accident & Sports Injury Clinic and Pamala A. Mitchell D.C..

Patient Signature: \_\_\_\_\_

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