

Dr. Name: _____ Other Dr. Names: _____

Exact Address: _____ City: _____ State: _____ Zip: _____

Clinic Name: _____

Office # _____ Fax # _____ Cell/Alt # _____

Morning		Evening	
Mon		Mon	Set appointments for every <u>Circle one</u> 15 min. 30 min.
Tues		Tues	
Wed		Wed	
Thurs		Thurs	
Fri		Fri	
Sat			

Number of patients per week desired: _____

Cross Streets: _____

Part of Town: _____

Directions (be very specific, include land marks):

School: _____

City: _____

Year Grad: _____

Month and year started at this office: _____

Federal programs to exclude: (circle)

Medicare Medicaid Others: _____

Type of Treatments: (circle)

Full Spinal Adjustments, Extremity, Activator, Diversified, Gonstead,
Atlas, Palmer, Thompson

Treatments: (circle)

Acupuncture, Electro stem, Therapist on Staff, MEDEX Rehab Therapy, Moist Heat/Ice,
Orthotics, Intersegmental Traction, Thompson Drop Bed, Trigger Point, Vibratory
Massage

Other Treatments (if any): _____