Piro Clinic of Natural Medicine
Dr. Janice M. Piro, DC, DABCI · Dr. Susan D. Player, DC, DABCI, DACBN · Dr. Andrew Sinclair, DC
971-B Virginia Ave
Palm Harbor, FL 34683
(727) 789-4020

Application for Treatment

Please check the type of care desired: Today's Date: ____/____/____
( )preventive ( )short-term ( )long-term ( )second opinion

Name: ____ Birth date: ____/____/____

Street Address: ____

City: ____ State: ____________ Zip: _______________

Home Phone: (______)______-_______ Work: (______)______-_______ Ext.: _______ Cell: (______)______-_______

E-Mail: ____

Marital Status: ( )single ( )married ( )widowed ( )divorced ( )separated

Name of Spouse or Significant Other: _________________________ Ages of Children: _____________________

Occupation: ______________________________ Spouse's Occupation: _______________________________

WILL YOU BE FILING FOR INSURANCE REIMBURSEMENT? ( )Yes ( )No

If Yes, is it Medicare? ( )Yes ( )No

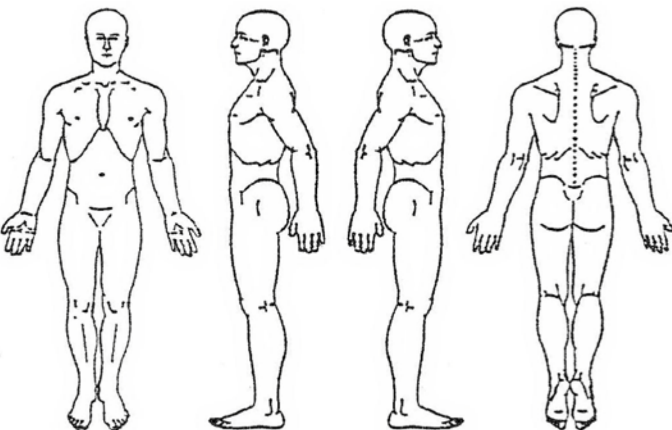
How did you hear of the Piro Clinic? Check all that apply:
( )mailer ( )magazine article ( )billboard ( )radio ( )website ( )word-of-mouth ( )search engine

Whom may we thank for referring you? ____

What is your goal regarding your health (be specific)? ____

____

If you are in pain, please mark the exact location(s) on the diagram below:



Major Concern

____

____

____

____

____

____

____

____

____

____

____

(Please Complete Reverse Side)

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 similar problem before? If yes, please explain: _______________________________

____

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

____

Is there anything you do that makes this condition worse? ____

____

Is there anything you can do that makes this condition better? ____

____

How has condition affected your life?

Home life ____

Occupation life ____

Recreational life ____

Rest and sleep ____

What surgeries have you had? ____

____

Are you pregnant? ( ) Yes ( ) No

Drugs you now take: ____

____

Vitamins you now take: ____

____

Have you consulted another health-care provider for this problem? ( ) Yes ( ) No

If yes, who, when and what is his/her specialty? ____

____

Please list any allergies: ____

____

Signature ____ Social Security # _______-______-________

(Parent/Legal Guardian if under 18)