

Patient Application For Treatment

TODAY'S DATE _____

ACCOUNT # _____

NAME _____ GENDER _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

MARITAL STATUS: S M D W NAME OF SPOUSE _____ # OF CHILDREN _____ AGES _____

OCCUPATION _____ EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ HAS ANY MEMBER OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? YES NO

HAVE YOU EVER BEEN TO A CHIROPRACTOR? YES NO HOW LONG HAS IT BEEN? _____

SOCIAL SERCURITY # _____ - _____ - _____ WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF AN EMERGENCY: CONTACT _____ PHONE _____

DO YOU EXERCISE? YES NO HOW OFTEN? _____ TYPE? _____

HAVE YOU EVER SUFFERED OR BEEN DIANOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

- | | | |
|--------------------------------|---------------------|---------------------|
| Y N *Broken or Fractured Bones | Y N *Osteoarthritis | Y N Eating Disorder |
| Y N Circulatory Problems | Y N Epilepsy | Y N Alcoholism |
| Y N *Rheumatoid Arthritis | Y N Pacemaker | Y N Drug Addiction |
| Y N Seizures/Convulsions | Y N Strokes | Y N HIV Positive |
| Y N A Congenital Disease | Y N *Cancer | Y N Gall Bladder |
| Y N Excessive Bleeding | Y N Ulcers | Y N *Head Problems |
| Y N High/Low Blood Pressure | Y N Ruptures | Y N Depression |
| Y N *Diabetes | Y N Coughing Blood | Y N Tumors |

*Explanation _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

NAME OF YOUR FAMILY DOCTOR _____ PHONE _____

ADDRESS _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING? Cancer Diabetes

Tuberculosis Heart Condition If yes, please explain: _____

For Doctor's Use Only

General

Injury Type:

Drug Allergies:

See Meds Addendum

DATE _____
 ACCT _____
 PATIENT _____

System Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

- High Blood Pressure _____
- Dizziness/Fainting _____
- Insomnia _____
- Low Resistance _____
- Tension _____
- Confusion _____
- Fatigue _____
- Ulcers _____
- Eye/Vision Problems _____
- Ear/Hearing Problems _____
- Difficulty Breathing _____
- Heart Problems _____
- Loss of Bladder Control _____
- Constipation _____
- Diarrhea _____
- Digestion Problems _____
- Nausea _____
- Female Problems _____
- Prostate Problems _____
- Diabetes _____
- Hands/Feet Cold _____
- Hand Tremors _____
- Loss of Memory _____
- Nervousness _____
- Sweaty Palms _____
- Speech Difficulty _____
- Anxiety _____
- Depression _____
- Irritability _____

For Doctor's Use Only	
DR.	
REVIEWED SYSTEMS	SYMPTOMS
_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity.
_____ Skin	Rashes, Eruptions, changes in warts or moles, pigmentation changes, bruising, itching hair loss, nail changes.
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____ Nose	Rhinorrhea, expistaxis, allergies, airway obstruction.
_____ Mouth& Throat	Ulcers, tooth pain, extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat.
_____ Neck	Stiffness, lumps, swelling, masses, pain
_____ Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats.
_____ Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope.
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
_____ Breasts	Self-examination, frequency, results, pain, nipple discharge, lumps, masses, skin dimpling.
_____ Gastrointestinal	Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
_____ Genitourinary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia.
_____ Endocrine	Polydipsia, polphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric.
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain
_____ Musculoskeletal	Bone, joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy.
_____ Neurological	Cranial Nerve defects, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia.
_____ Psychological	Mood swings, depression, anxiety, phobias.

Problem/ Medication List

Dr.Name/Facility	Problem	Type of Treatment	From When to When?	Name of Medication/Vitamin	Who Prescribed Dr / Self

Date _____

Acct _____

Patient _____

PATIENT HISTORY

1. What is your main complaint? _____

2. On the scale below, please circle the severity of your main complaint (At it's worst)

None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

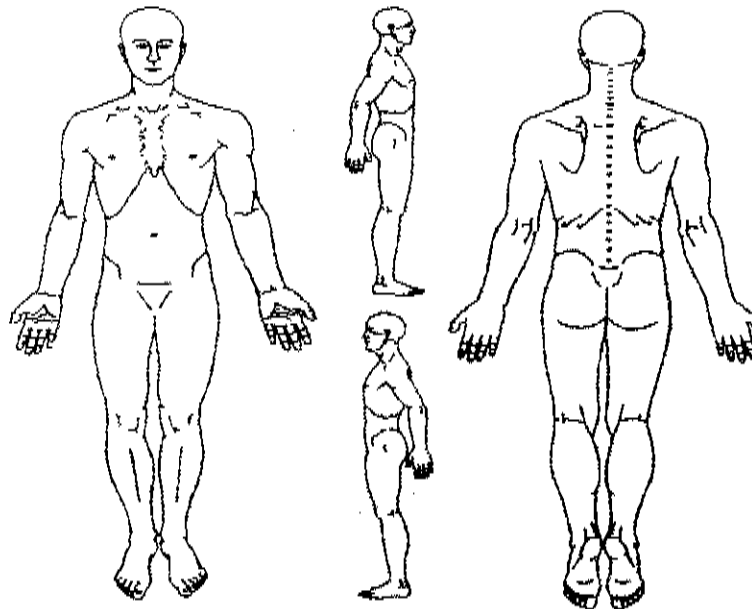
3. On the scale below, please circle the percentage of time you experienced your main complaint:

Occasional			Intermittent			Frequent			Constant	
0	10	20	30	40	50	60	70	80	90	100

4. How long have you been experiencing your main complaint? _____

5. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



6. When do you notice it most? AM PM

How long does it last? _____ Mins _____ Hrs

7. What makes it feel better? _____

8. What makes it feel worst? _____

9. Have you ever had this problem in the past? Yes No

10. I have Be hospitalized Been treated by another chiropractor Been treated by another specialty provider
 Never received care for this problem.

11. Have you lost time from work because of it? Yes No Dates? _____ To _____

12. Are you pregnant? Yes No

13. What was the first day of your last menstrual cycle? _____

14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

____ Personal Care ____ Lifting ____ Reading ____ Concentrating ____ Work ____ Driving ____ Sleeping
____ Recreation ____ Walking ____ Sitting ____ Standing ____ Social Life

Patient Signature _____ Date _____