PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ ACCOUNT #: _____

SS#: ___-___-_____

NAME: _____ GENDER: _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

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

HAS ANY MEMBER OF YOUR FAMILY RECEIVED CHRIOPRACTIC CARE? YES NO

OCCUPATION: _____ EMPLOYER: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HAVE YOU EVER BEEN TO A CHIROPRACTIC CARE? YES NO

WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

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

HAVE YOU EVER SUFFERED OR BEEN DIAGNOSED AS HAVING:

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

*Explanation _____

_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOVLED 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 Doctors Use Only

☐ General

Injury Type:

Drug Allergies:

☐ See Meds Addendum

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON Rx STRENGTH	Rx STRENGTH	START DATE	STOP DATE	WHO PRESCRIBED DR. / SELF	

DATE: _____

ACCT: _____

PATIENT: _____

SYSTEMS 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 ____
Irritablility ____

FOR DOCTORS'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 lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____	Nose	Rhinorrhea, epistaxis, 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	Unusal diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, sonstipation, change in bowel habits, jaundice, abdominal swelling
_____	Genitournary	Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
_____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node elargement/pain
_____	Musculoskelatal	Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
_____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

❑ Reviewed External H P
❑ Release Records H P
❑ Request Records H P

EXTERNAL DX'D: _____

DISABILITIES:

IMPAIRMENTS:

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)

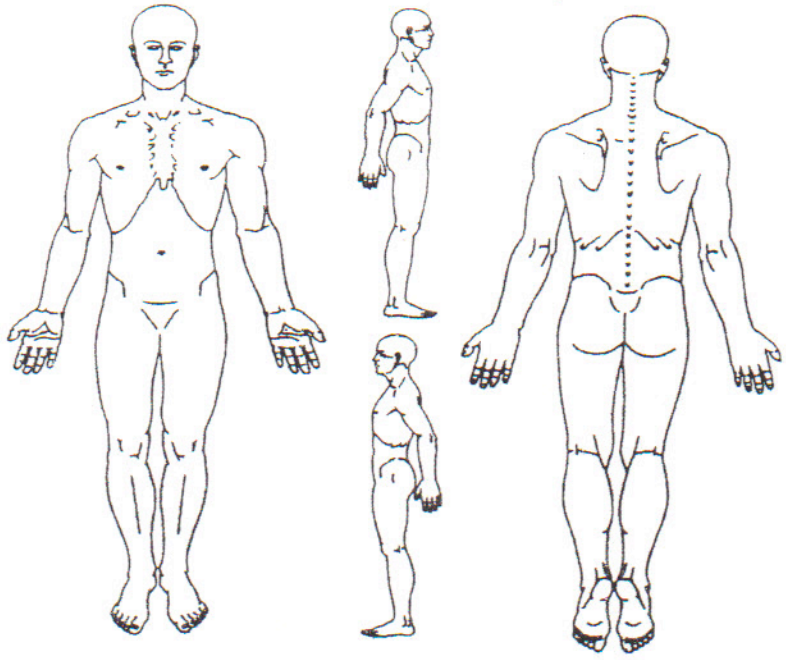
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience 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 worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never recieved 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 ____

Signature:_____

Date: ____/____/____