PATIENT APPLICATION FOR TREATMENT

Today's Date: _____ Acct # _____

Name: _____ How would you like to be addressed? _____

Date of Birth: _____ Age: _____ Gender: _____

Your Address: _____ City: _____

State: _____ Zip: _____ SS #: _____ Home #: _____

Your Occupation: _____ Wk #: _____

Emergency Contact_____ Ph #:_____ Cell #: _____

Maritial Status **S M W D**

How many children do you have? _____ What are their ages? _____

Have they or any other members of your family received chiropractic care? ❑ Yes ❑ No

Have you ever had chiropractic care? ❑ Yes ❑ No How long has it been? _____

The purpose or reason for this Appointment? _____

How often do you drink alcoholic beverages? _____

Do you smoke? ❑ Yes ❑ No How much? _____

Do you exercise ❑ Yes ❑ No How often? _____ Type? _____

Do you have any allergies? (Specify): _____

Have you ever suffered from or been diagnosed 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? _____

When was the last time you were involved in an accident of any kind? _____

Primary Care Physician _____

How did you hear about us? _____

_____

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S

Use back if necessary for additional medications list

FOR DOCTOR'S USE ONLY

❑ General

Injury Type:

❑ NDRA

Drug Allergies:

❑ See Meds Addendum

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)

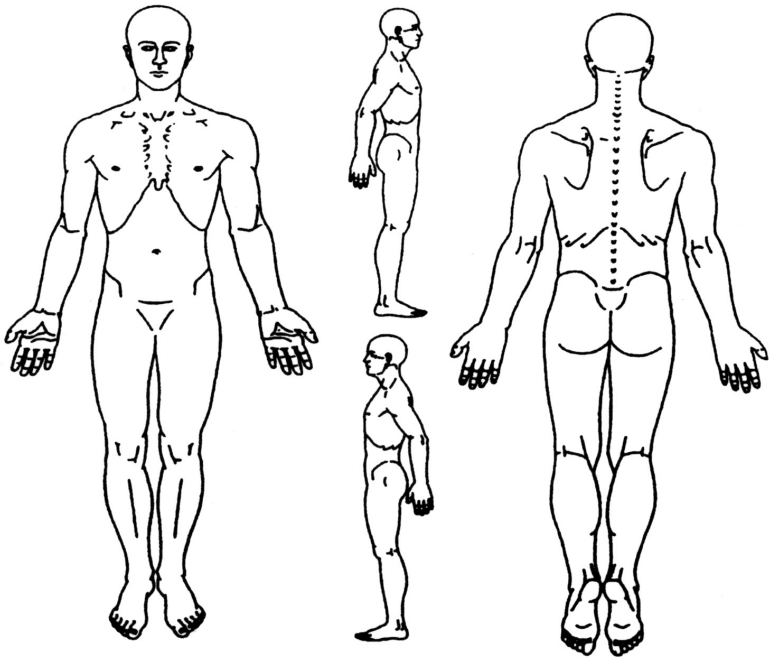
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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 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? _____

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: ____/____/____