

## PATIENT APPLICATION FOR TREATMENT

Today's Date: \_\_\_\_\_ Acct #: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Wk #: \_\_\_\_\_

SS#: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Marital Status **S M W D** # of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

Do you have insurance?  Yes  No Company: \_\_\_\_\_ Ph #: \_\_\_\_\_

Insured's name on card: \_\_\_\_\_ Insured's date of birth: \_\_\_\_\_

Have you ever had chiropractic care?  Yes  No How long has it been?: \_\_\_\_\_

When was your last physical exam?: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

When was the last time you were involved in an accident of any kind?: \_\_\_\_\_

The purpose or reason for this appointment?: \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No How much and how often?: \_\_\_\_\_

Do you smoke?  Yes  No How much and how often?: \_\_\_\_\_

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: \_\_\_\_\_

| MEDICATION LIST     |                   |                 |             |              |              |                |      |
|---------------------|-------------------|-----------------|-------------|--------------|--------------|----------------|------|
| Names of Medication | Names of Vitamins | Non-Rx Strength | Rx Strength | Date Started | Date Stopped | Who Prescribed |      |
|                     |                   |                 |             |              |              | DR             | Self |
|                     |                   |                 |             |              |              | DR             | Self |
|                     |                   |                 |             |              |              | DR             | Self |
|                     |                   |                 |             |              |              | DR             | Self |
|                     |                   |                 |             |              |              | DR             | Self |
|                     |                   |                 |             |              |              | DR             | Self |

DATE: \_\_\_\_\_

ACCT: \_\_\_\_\_

PATIENT: \_\_\_\_\_

## SYSTEMS REVIEW

In the left-handed 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 _____              |          |
| SYSTEMS               | SYMPTOMS |
| General               | _____    |
| Skin                  | _____    |
| Head                  | _____    |
| Eyes                  | _____    |
| Nose                  | _____    |
| Mouth & Throat        | _____    |
| Neck                  | _____    |
| Lungs                 | _____    |
| Cardiac               | _____    |
| Vascular              | _____    |
| Breasts               | _____    |
| Gastrointestinal      | _____    |
| Genitourinary         | _____    |
| Endocrine             | _____    |
| Hematopoietic         | _____    |
| Musculoskeletal       | _____    |
| Neurological          | _____    |
| Psychological         | _____    |

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

| DR NAME/FACILITY | PROBLEM | TYPE OF TREATMENT RECEIVED | DATES |
|------------------|---------|----------------------------|-------|
|                  |         |                            |       |
|                  |         |                            |       |
|                  |         |                            |       |

**FOR DOCTOR'S USE ONLY**

Reviewed External H P

Release Records H P

Requested Records H P

External Dx'D: \_\_\_\_\_

Disabilities: \_\_\_\_\_

Impairments: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Acct: \_\_\_\_\_

## 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

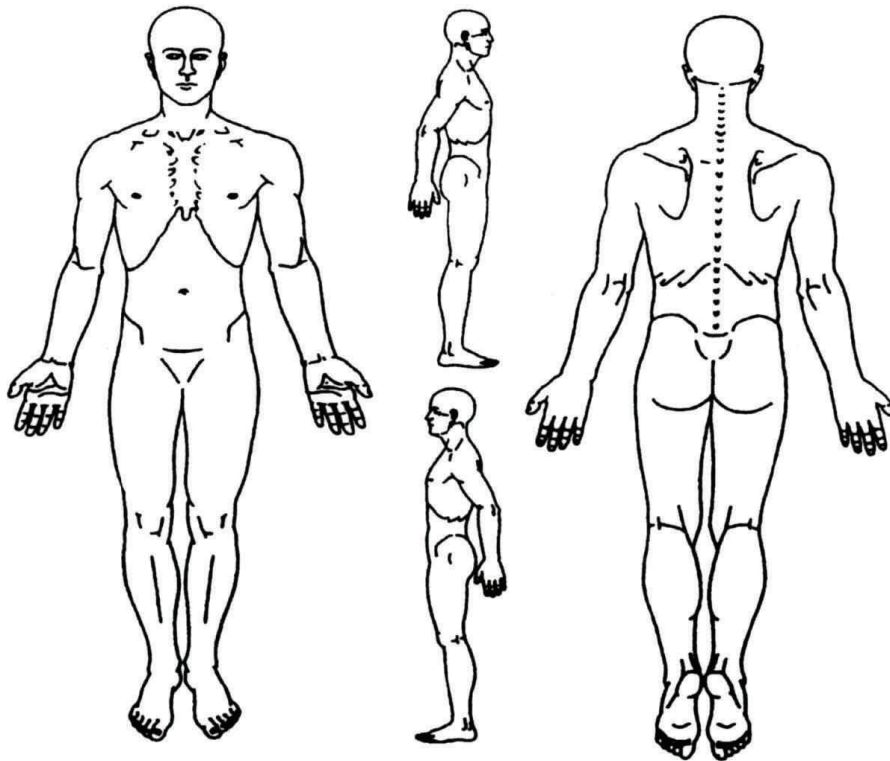
C: cramping

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: \_\_\_\_\_

12. Are you Pregnant?  Yes  No

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

14. Number of pregnancies? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Acct: \_\_\_\_\_

## ACTIVITIES OF DAILY LIVING

Which of the following activities do you notice your symptoms with?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Sitting             | <input type="checkbox"/> Concentrating         | <input type="checkbox"/> Eating                                     |
| <input type="checkbox"/> Standing            | <input type="checkbox"/> Bathing               | <input type="checkbox"/> Getting dressed                            |
| <input type="checkbox"/> Bending             | <input type="checkbox"/> Gardening             | <input type="checkbox"/> Socializing                                |
| <input type="checkbox"/> Working on computer | <input type="checkbox"/> Cleaning              | <input type="checkbox"/> Working                                    |
| <input type="checkbox"/> Lifting             | <input type="checkbox"/> Exercising            | <input type="checkbox"/> Climbing stairs                            |
| <input type="checkbox"/> Driving             | <input type="checkbox"/> Playing Sports        | <input type="checkbox"/> Squatting                                  |
| <input type="checkbox"/> Bathing             | <input type="checkbox"/> Picking up children   | <input type="checkbox"/> Rising from seated position                |
| <input type="checkbox"/> Walking             | <input type="checkbox"/> Playing with children | <input type="checkbox"/> Personal care (shaving,<br>doing your hair |
| <input type="checkbox"/> Running             | <input type="checkbox"/> Watching TV           |   |
| <input type="checkbox"/> Reading             | <input type="checkbox"/> Falling asleep        |   |
| <input type="checkbox"/> Writing             | <input type="checkbox"/> Staying asleep        |   |

I have answered the above questions to the best of my ability.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_