PATIENT APPLICATION FOR TREATMENT

Today's Date:		Account #	
Last name:	First:	Middle:	
How would you like to be addressed?			
Date of Birth:	Age:	Gender ☐ M ☐ F	
Your address:		City:	State:
Zip:	Cell#	Home #	Email:
Your Occupation?		Wk #	

Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐

Emergency Contact? Emergency Phone #

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?

What is 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 much?

Do you have any allergies? (Specify):

Have you ever suffered from or been diagnosed as having (check Yes or No for each):

*Broken or Fractured Bones	☐Yes ☐No	*Osteoarthritis	☐Yes ☐No	Eating Disorder	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	Epilepsy	☐Yes ☐No	Alcoholism	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No	Pacemaker	☐Yes ☐No	Drug Addiction	☐Yes ☐No
Seizures/Convulsions	☐Yes ☐No	Strokes	☐Yes ☐No	HIV Positive	☐Yes ☐No
A Congenital Disease	☐Yes ☐No	*Cancer	☐Yes ☐No	Gall Bladder	☐Yes ☐No
Excessive Bleeding	☐Yes ☐No	Ulcers	☐Yes ☐No	*Head Problems	☐Yes ☐No
High/Low Blood Pressure	☐Yes ☐No	Ruptures	☐Yes ☐No	Depression	☐Yes ☐No
*Diabetes	☐Yes ☐No	Coughing Blood	☐Yes ☐No	Tumors	☐Yes ☐No

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

*Explanation:_____

When was your last physical exam?

All information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release any information required to process my claims. I consent to allow the Doctor to treat my condition as he/she deems appropriate.

Patient / Guardian Signature:_____ Date:_____

FOR DOCTOR'S USE ONLY

☐ General

Injury Type

☐ General

Drug Allergies:

☐ See Meds Addendum

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DR. _____

PATIENT: _____ DATE: _____

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) all conditions you are currently experiencing, or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Please complete all lines without leaving any blanks.

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

FOR DOCTOR USE ONLY

DR. REVIEWED	SYSTEMS	SYMPTOMS
____	General	Weight changes, fatigue, anorexia, weakness, fever, chill, 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, cortomata, pain, excessive lacrimation, redness, discharge
____	Nose	Rhinorrhea, epistaxis, allergies, alrway obstruction
____	Mouth & Throat	Ulcers, tooth pain/extractions, tempormanbibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
____	Neck	Stiffness, lumps/swelling/masses, pain
____	Lungs	Cough (productive/nonproductive), hemopysis, dyspnea, pain with respiration, wheezing, night sweats.
____	Cardiac	Palpitations, chest pain, orhopnea, 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, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
____	Genitournary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematurea, sexually transmitted disease, dyspareunia, scrotal mass (male), hernia
____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitsm, menstruation history, pregnancy history, dysmonorrhea, premenstrual syndrome, climacteric
____	Hematopoletic	Anemia, abdominal bleeding, lymph node elargement/pain.
____	Musculoskelatal	Bone/Joint pain, selling, joint deformity, trauma, restricted range of motion, weakness, atrophy
____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paraly-sis, tremors, staxis, loss of balance, numbness, parenthesia
____	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 REC'D	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:

PATIENT: _____ Dr: _____

DATE: _____

PATIENT HISTORY

1. What is your **main complaint?** _____

2. Using the scale below, indicate the **severity** of your **main complaint** (when at its worst) _____

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

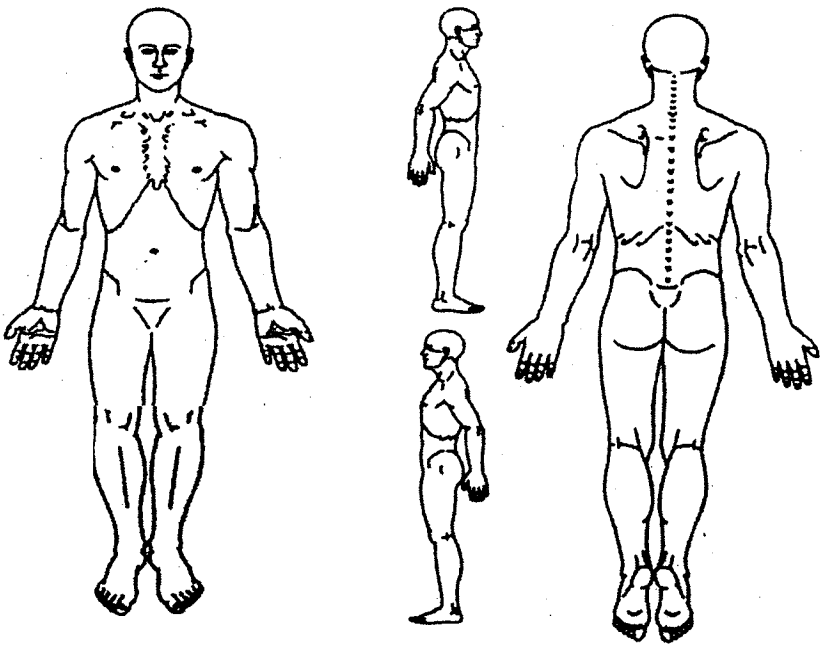
3. Using the scale below, indicate the **percentage of time** you experience your **main complaint**: _____ %

	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? from _____ to _____
12. Are you pregnant? ☐Yes ☐No
13. What was the first day of your last menstrual cycle? _____
    Number of pregnancies? _____ Miscarriages? _____

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

personal care	☐Yes	☐No
lifting	☐Yes	☐No
reading	☐Yes	☐No
concentrating	☐Yes	☐No
work	☐Yes	☐No
driving	☐Yes	☐No
sleeping	☐Yes	☐No
recreation	☐Yes	☐No
walking	☐Yes	☐No
sitting	☐Yes	☐No
standing	☐Yes	☐No
social life	☐Yes	☐No

Signature: _____

Date: _____

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