Patient Application For Treatment:

Today's Date: ___________ E-mail: ______________________ Gender: M F
Name: __________________________________ Date of Birth: _________ Age: ________
Your Address: ____________________________________
City: __________________________ State: _____ Zip: __________
SS #: ___________________ Home #: _____________ Cell #: ______________
Name of Employer: ________________________________ Work #: _____________

Martial Status: S M W D Referred By: ______________________
How Many Children Do You Have? ________ What Are Their Ages?
____
Have You Or Any Other Members of Your Family Received Chiropractic Care? `Yes `No
How Long Has It Been? __________
Emergency Contact: ______________________________ Phone #: _____________

Who Is Responsible For Your Bill? `Self `Spouse `Worker's Compensation `Medicaid `Medicare `Auto Insurance `Personal Health Insurance `Other: ____________________

Purpose Or Reason For Today's Appointment?
____
How Often Do You Drink Alcoholic Beverages? _______
Do You Smoke? `Yes `No How Much? ________________
Do You Exercise? `Yes `No How Much? _______________ Type? ________________
Do You have Any Allergies? Yes No 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	*Cancer/Tumors	Y	N	Alcoholism
Y	N	Fibromyalgia	Y	N	Pacemaker	Y	N	Drug Addition
Y	N	*Rheumatoid Arthritis	Y	N	Strokes	Y	N	HIV Positive
Y	N	Osteoarthirits	Y	N	Epilepsy	Y	N	Sinusitis/Rhinitis
Y	N	Lupus	Y	N	Ulcers	Y	N	Gall Bladder
Y	N	High Cholesterol	Y	N	Coughing Blood	Y	N	Excessive Bleeding
Y	N	High/Low Blood Pressure	Y	N	Eating Disorder	Y	N	Seizures/Convulsions
Y	N	*Diabetes	Y	N	Depression			

*Explain:
____

Medication List

Name of Medications	Name of Vitamins	Date Started	Date Stopped

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). Do not leave any blanks.

_____ Dizziness / Fainting
_____ Insomnia
_____ Tension
_____ Confusion
_____ Fatigue
_____ Eye/Vision Problems
_____ Ear/Hearing Problems
_____ Difficulty Breathing
_____ Heart Problems
_____ Loss of Bladder Control
_____ Constipation
_____ Diarrhea
_____ Digestion Problems
_____ Nausea
_____ Female Problems
_____ Prostate Problems
_____ Hands / Feet Cold
_____ Loss of Memory
_____ Nervousness
_____ Sweaty Palms
_____ Speech Difficulty
_____ Anxiety
_____ Irritability

Anyone in your family have or had:

___ stroke
___ arthritis
___ cancer
___ hypertension
___ heart problems
___ diabetes

Doctors Use Only:

_____	General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____	Skin	Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
_____	Head	Trauma, headaches, dizziness, light headed
_____	Eyes	Changes in acuity 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	Palpations, 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, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, hematures, sexually transmitted diseases, dyspareunia, scrotal swelling
_____	Genitournary	Polyuria nocturia, oliguria, dysuria, uregency, incontinence, urine color change
_____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstruation, history, pregnancy history, dysmenorrheal, premenstrual syndrome, climacteric
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement,/pain
_____	Musculoskelatal	Bone/joint pain, swelling, joint deformity, trama, restricted ROM, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, parasthesia
_____	Psychological	Mood swings, depression, anxiety, phobias

For

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

Problems List

Dr. Name/Facility	Problem	Treatment Received	When to When
1.			
2.			
3.			

Patient Name: ______________________ Date: __________ Acct# ___________

Date: __________ Patient Name: _________________________ Account# ______________

PATIENT HISTORY

Complaint #1: ________________________________ When did it start? _______________

Circle the current **pain level** of your complaint: 0 1 2 3 4 5 6 7 8 9 10
Mild **Moderate** **Severe**

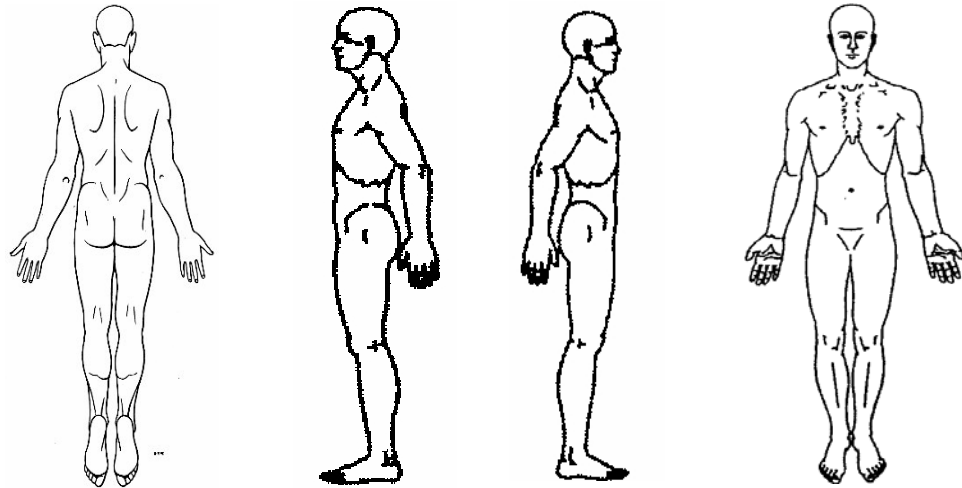
Circle the **percentage** of time you experience the complaint: 0 10 20 30 40 50 60 70 80 90 100 %
Occasional **Intermittent** **Frequent** **Constant**

When do you feel it most? □ AM □ PM When present, how long does the complaint last? _____min _____Hrs

What makes you feel better? ______________________ What make if feel worse? ____________________

Using the letters below, please show **where** you are experiencing **all** of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Activity			Activity		
Walking	□Y	□N	Bending	□Y	□N
Sleeping	□Y	□N	Kneeling	□Y	□N
Sitting	□Y	□N	Lifting Children	□Y	□N
Personal Grooming	□Y	□N	Lifting Objects	□Y	□N
Standing	□Y	□N	Running	□Y	□N
Driving	□Y	□N	Exercising	□Y	□N
Housework	□Y	□N			

1. Have you ever had the condition(s) in the past? □ Yes □ No If yes, please indicate if any treatment was received and what type of treatment: □ Hospitalization □ Chiropractic care □ Medical doctor / specialty provider □ None
2. Have you ever lost time from work due to your condition(s)? □ Yes □ No If Yes, dates? _______________
3. Are you pregnant? □ Yes □ No
4. What was the first day of your last menstrual cycle? ____________________
5. Number of pregnancies? __________ Number of miscarriages? ___________

Patient Signature ____________________________ **Date:** _____________ **Physician Initials:** ______