



PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ e-mail: _____
 NAME: _____ HOW DID YOU HEAR ABOUT OUR OFFICE ? _____
 YOUR ADDRESS: _____ CITY: _____
 STATE: _____ ZIP: _____ SS #: _____ HOME #: _____
 YOUR OCCUPATION: _____ CELL #: _____
 EMERGENCY CONTACT _____ PH #: _____
 Date of Birth: _____ Age: _____ Gender: _____
 MARITAL STATUS **S M W D** Height _____ Weight _____ lbs
 HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____
 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): _____ **FOR DOCTOR'S USE ONLY**

- 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? _____

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
						D S

GENERAL

INJURY TYPE:

NDRA

DRUG ALLERGIES:

SEE MEDS ADDENDUM

PATIENT: _____

DATE: _____

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.

		FOR DOCTORS'S USE ONLY	
		DR. REVIEWED	SYMPOMS
High Blood Pressure	_____	_____	General Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
Dizziness/Fainting	_____	_____	Skin Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
Insomnia	_____	_____	Head Trauma, headaches, dizziness, light headed
Low Resistance	_____	_____	Eyes Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
Tension	_____	_____	Nose Rhinorrhea, epistaxis, allergies, airway obstruction
Confusion	_____	_____	Mouth & Throat Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
Fatigue	_____	_____	Neck Stiffness, lumps/swelling/masses, pain
Ulcers	_____	_____	Lungs Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
Eye/Vision Problems	_____	_____	Cardiac Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
Ear/Hearing Problems	_____	_____	Vascular Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
Difficulty Breathing	_____	_____	Breasts Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
Heart Problems	_____	_____	Gastrointestinal Unusal diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling
Loss of Bladder Control	_____	_____	Genitourinary Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematuria, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
Constipation	_____	_____	Endocrine Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
Diarrhea	_____	_____	Hematopoietic Anemia, abdominal bleeding, lymph node enlargement/pain
Digestion Problems	_____	_____	Musculoskeletal Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
Nausea	_____	_____	Neurological Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
Female Problems	_____	_____	Psychological Mood swings, depression, anxiety, phobias
Prostate Problems	_____		
Diabetes	_____		
Hands/Feet Cold	_____		
Hand Tremors	_____		
Loss of Memory	_____		
Nervousness	_____		
Sweaty Palms	_____		
Speech Difficulty	_____		
Anxiety	_____		
Depression	_____		
Irritability	_____		

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:



PATIENT: _____

DATE: _____

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)

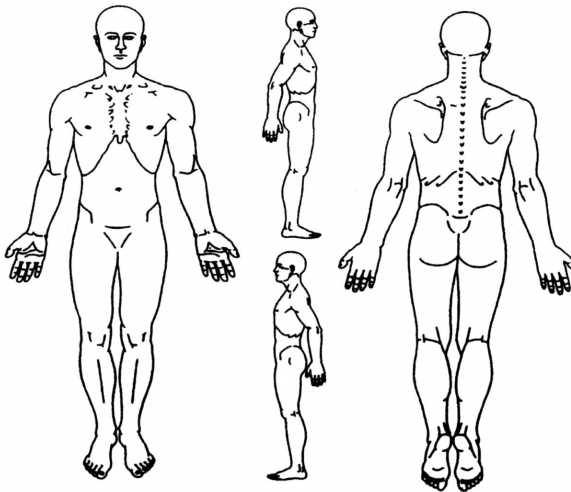
None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

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



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	_____

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? _____
14. Number of pregnancies? _____ Miscarriages? _____

Signature: _____

Date: ___/___/___