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: __________________________________ WK #: ____________

EMERGENCY CONTACT_____________________________ PH #:_______ CELL #: ____________

Date of Birth: _____________ Age: ____________ Gender: ____________

MARITIAL 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): _______________________________________

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

FOR DOCTOR'S USE ONLY

____

GENERAL

INJURY TYPE:

NDRA

DRUG ALLERGIES:

SEE MEDS ADDENDUM

PATIENT: ______________________________ CHIROPRACTIC® 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.

Condition	
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
______	Genitourinary	Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dys-pareunia, 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, paraly-sis, 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:

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)

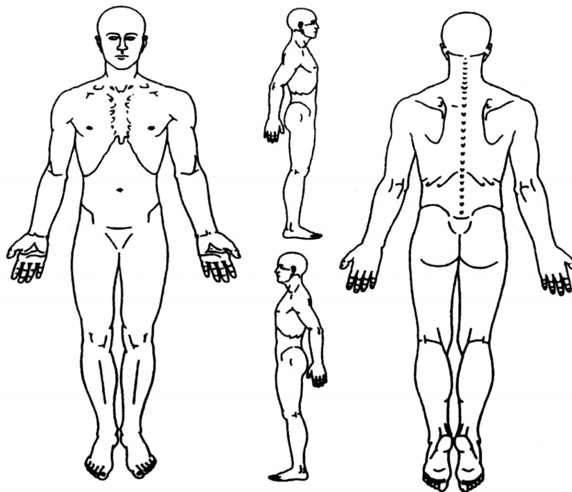
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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: ____/____/____