PATIENT APPLICATION FOR TREATMENT

DATE: ______________ EMAIL: ________________________________ PREFERRED CONTACT: TEXT | EMAIL | PHONE
NAME: ___________________________________ HOW DID YOU HEAR ABOUT OUR OFFICE ?_____________________
ADDRESS: ____ CITY:__________________________
STATE: ________ ZIP: ____________ SS #: __________________ HOME #:____________________
YOUR OCCUPATION: ______________________________________ WK #: ____________________
EMERGENCY CONTACT_________________________PH #:_________________ CELL #: _____________________
DATE OF BIRTH: ______________ AGE: _____________ GENDER: **M | F** CELL PROVIDER _______________
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**
						D	**S**

FOR DOCTOR'S USE ONLY

____

GENERAL

INJURY TYPE:

NDRA

DRUG ALLERGIES:

SEE MEDS ADDENDUM

DATE: ____________

ACCT: _________________

PATIENT: ______________________________

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.

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:

DATE: ____________
ACCT: _________________
PATIENT: _____________________________

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)

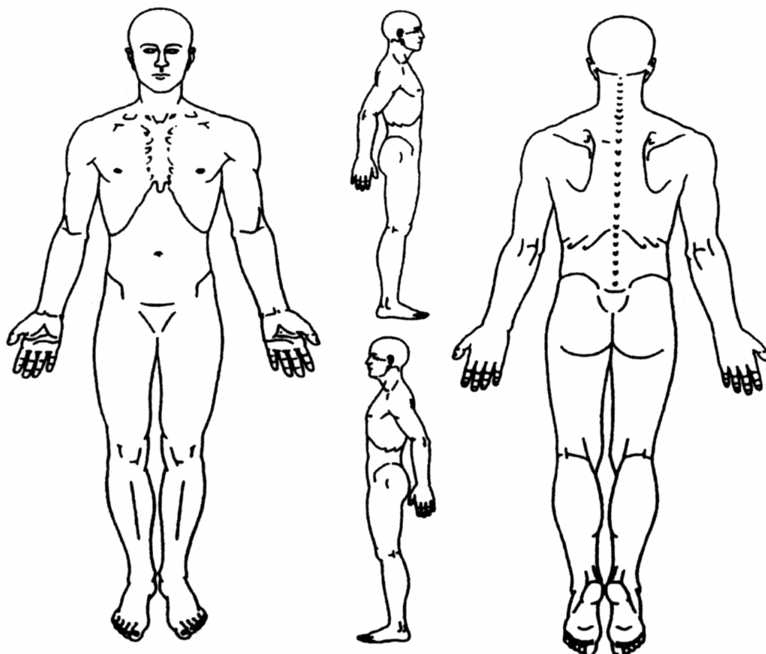
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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?____________ to _____________
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? ____________
14. Number of pregnancies? _______ Miscarriages? ______________

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 ____

Signature:_______________

Date: ____/____/____