

# PATIENT APPLICATION FOR TREATMENT

## General Information

Today's Date: \_\_\_\_\_ Account# \_\_\_\_\_

Name: \_\_\_\_\_

How would you like to be addressed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Gender: M F

SS# \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_

Work Address: \_\_\_\_\_ Occupation \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_ Extension: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone# \_\_\_\_\_

How did you hear about us? (circle one) Person's Name: \_\_\_\_\_

AT&T/DEX Yellow Pages Yellow Book First Choice Yellow Pages YellowPages.com

Internet Search Engine: Yahoo Google MSN Key Words Used: \_\_\_\_\_

Welcome Wagon Newspaper Flyer Other \_\_\_\_\_

## Family Information

Marital Status: S M W D Spouse Name: \_\_\_\_\_

How many children do you have? \_\_\_\_

Names: \_\_\_\_\_ Age: \_\_\_\_ Gender: M F

\_\_\_\_\_ M F

\_\_\_\_\_ M F

\_\_\_\_\_ M F

Have they or any other member ever received chiropractic care? Y N

## Personal Information

Have you ever had chiropractic care? Y N How long ago? \_\_\_\_

The reason for this appointment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Acct: \_\_\_\_\_

## PATIENT HISTORY

How much water do you drink daily? \_\_\_\_\_

Do you drink alcohol? Y N How much? \_\_\_\_\_

Do you drink coffee? Y N How much? \_\_\_\_\_

Do you drink pop? Y N How much? \_\_\_\_\_

Do you smoke? Y N How many per day? \_\_\_\_\_ How long? \_\_\_\_\_

Do you exercise? Y N How often? \_\_\_\_\_ Type: \_\_\_\_\_

Do you have allergies? (Specify) \_\_\_\_\_

Have you ever suffered or been diagnosed as having: (circle yes or no for each)

Y N	Broken/Fractured Bones	Y N	Osteoporosis	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	Osteoarthritis	Y N	Strokes	Y N	HIV Positive
Y N	Congenital Disease	Y N	Cancer	Y N	Sleep Disorder/Insomnia
Y N	Excessive Bleeding	Y N	Tumors/Fibroids	Y N	High/Low Blood Pressure
Y N	Seizures/Convulsions	Y N	Diabetes	Y N	Fibromyalgia
Y N	Coughing Blood	Y N	Ulcers	Y N	Depression

If you marked yes to any of the above, please explain: \_\_\_\_\_

Have you ever been in a motor vehicle accident or had any traumas? If so, please describe:

When was your last Physical Exam? \_\_\_\_\_ X-rays? \_\_\_\_\_

### Medications

Name of Medication	Reason for Taking	Non Rx Strength	Rx Strength	Date Started	Date Stopped	Prescribed By
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self
						Doctor Self

Are you taking any vitamins? Y N Types of vitamins: \_\_\_\_\_

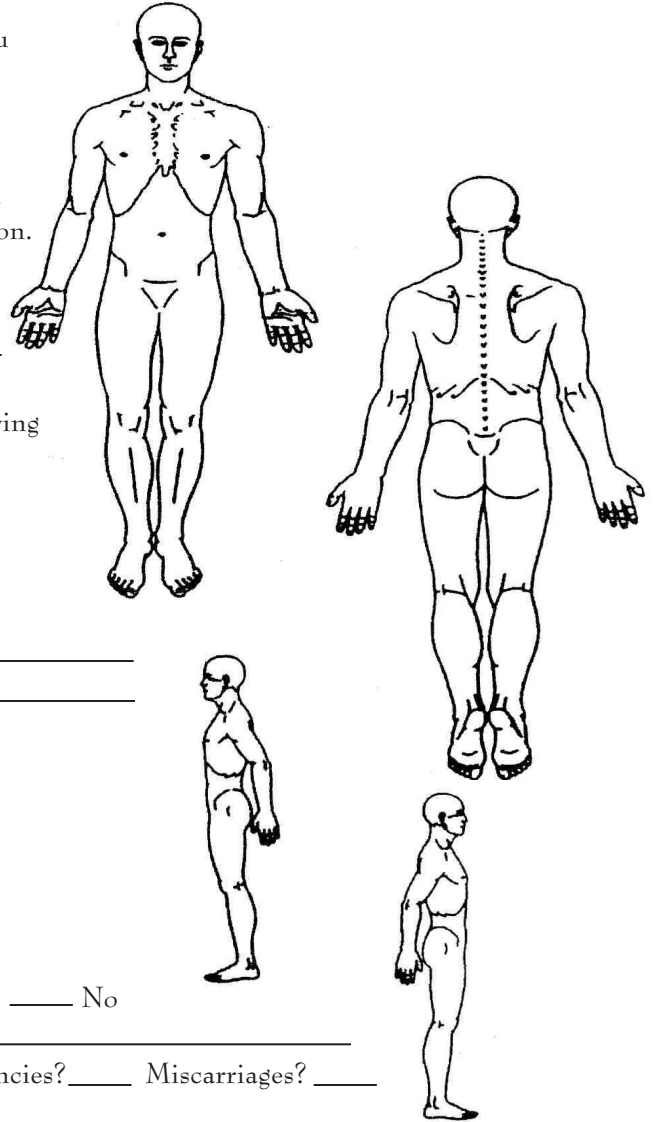
\_\_\_\_\_  
\_\_\_\_\_

# PATIENT HISTORY

1. What is your main complaint? \_\_\_\_\_
2. On the scale below, please circle the **severity** of your **main complaint** (at its worst)
 

None	Slight	Mild	Moderate	Severe						
0	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. a. When did your symptoms first begin? \_\_\_\_\_  
 \_\_\_\_\_ This is the first time I am experiencing this condition.  
 \_\_\_\_\_ This is an exacerbation of a previous condition.  
 b. What were you doing when your symptoms began?  
 \_\_\_\_\_
5. On the diagram to the right, please show **where** you were experiencing **all** of the **present complaints** using the following letters:  
 A: ache B: burning pain C: cramping D: dull pain  
 R: throbbing pain N: numbness T: tingling
6. a. When do you notice it most? \_\_\_\_\_ AM \_\_\_\_\_ PM  
 b. How long does it last? \_\_\_\_\_ Mins \_\_\_\_\_ Hrs
7. What makes it feel better? \_\_\_\_\_
8. What makes it feel worse? \_\_\_\_\_
9. I have been  
 \_\_\_\_\_ hospitalized for this problem  
 \_\_\_\_\_ treated by another chiropractor  
 \_\_\_\_\_ treated by another specialty provider  
 \_\_\_\_\_ not received care for this problem
10. Have you lost work time because of it? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Dates: \_\_\_\_\_ to \_\_\_\_\_
11. Are you experiencing any other health concerns? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Please explain: \_\_\_\_\_
12. Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No Number of pregnancies? \_\_\_\_\_ Miscarriages? \_\_\_\_\_
13. What was the first day of your last menstrual cycle? \_\_\_\_\_



Do you have **pain and/or difficulty** performing any of the following activities? (check all that apply)

<input type="checkbox"/> Personal care/grooming	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Lifting	<input type="checkbox"/> Recreational activities/hobbies
<input type="checkbox"/> Reading	<input type="checkbox"/> Walking
<input type="checkbox"/> Concentrating	<input type="checkbox"/> Sitting
<input type="checkbox"/> Working	<input type="checkbox"/> Standing
<input type="checkbox"/> Driving	<input type="checkbox"/> Social activities

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Acct: \_\_\_\_\_

## SYSTEMS REVIEW

Please indicate with a (C) conditions you have now or with a (P) the conditions that you have had in the past. If neither applies, mark NA. Please do not leave blanks.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Hands/Feet Cold   |
| <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Heart Problems          | <input type="checkbox"/> Hand Tremors      |
| <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Loss of Memory    |
| <input type="checkbox"/> Low Resistance       | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Nervousness       |
| <input type="checkbox"/> Tension              | <input type="checkbox"/> Diarrhea                | <input type="checkbox"/> Sweaty Palms      |
| <input type="checkbox"/> Confusion            | <input type="checkbox"/> Digestion Problems      | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Female Problems         | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Eye/Vision Problems  | <input type="checkbox"/> Prostate Problems       | <input type="checkbox"/> Irritability      |
| <input type="checkbox"/> Ear/Hearing Problems | <input type="checkbox"/> Diabetes                |  |

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

Doctor's Name/Facility	Surgery/Treatment	Procedure Received	Date(s) of Procedure

### For Doctor's Use Only

Dr. Reviewed	Systems	Symptoms	Dr. Comments
	General	Weight changes, fatigue, anorexia, weakness, fever, changes in activity	
	Skin	Rashes, eruptions, changes in warts, moles, or pigmentation, bruising, itching, hair loss, nail changes	
	Head	Trauma, headaches, dizziness, light headed	
	Eyes	Changes in acuity in vision, use of corrective lenses, blurred vision, increased tearing, redness, discharge, pain	
	Nose	Rhinorrhea, epinitis, allergies, airway obstruction	
	Mouth & Throat	Ulcers, tooth pain/extraction, TMJ pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep	
	Neck	Stiffness, lumps/swelling/masses, pain	
	Lungs	Cough (productive/non productive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats	
	Cardiac	Palpitation, 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	Usual diet, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis	
		Stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling, BM frequency	
	Genitourinary	Polyuria, dysuria, urgency, stress incontinence, urine color changes, hematuria, STD, nocturia, hernia, scrotal mass	
	Endocrine	Polydispia, polyphagia, temp. intolerance, tremors, goiter, alopecia, dysmenorrhea, PMS, menstrual hx, pregnancy hx	
	Hemtopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain	
	Musculoskeletal	Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy	
	Neurological	Cranial nerve deficits, seizures, LOC, tremors, stasis, loss of balance, numbness, paresthesia	
	Psychological	Mood swings, depression, anxiety, phobias	

Doctor's Initials \_\_\_\_\_