



Patient Application For Treatment

Today's Date: _____ E-mail: _____ Gender: M F
 Name: _____ Date of Birth: _____ Age: _____
 Your Address: _____ City: _____
 State: _____ Zip: _____ SS #: _____ Home #: _____
 Name of Employer: _____ Work #: _____
 Marital Status: S M W D Referred By: _____ Cell #: _____
 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 Ulcers |
| Y N Circulatory Problems | Y N Ruptures |
| Y N Rheumatoid Arthritis | Y N Coughing Blood |
| Y N Seizures/Convulsions | Y N Osteoarthritis |
| Y N A Congenital Disease | Y N Eating Disorder |
| Y N Excessive Bleeding | Y N Alcoholism |
| Y N High/Low Blood Pressure | Y N Drug Addition |
| Y N Diabetes | Y N HIV Positive |
| Y N Epilepsy | Y N Gall Bladder |
| Y N Pacemaker | Y N *Head Problems |
| Y N Strokes | Y N Depression |
| Y N *Cancer | Y N Tumors |

Explain: _____

Medication List

Name of Medication	Name of Vitamins	Date Started	Date Stopped

Healthcare Provider Team

Other providers seen for the same condition: _____

Who is currently your
 Chiropractor: _____
 Primary Care Physician: _____
 Physical Therapist: _____
 Dentist: _____

Massage Therapist: _____
 Personal Trainer: _____
 Acupuncturist: _____
 Health Club: _____
 Other: _____

Date: _____

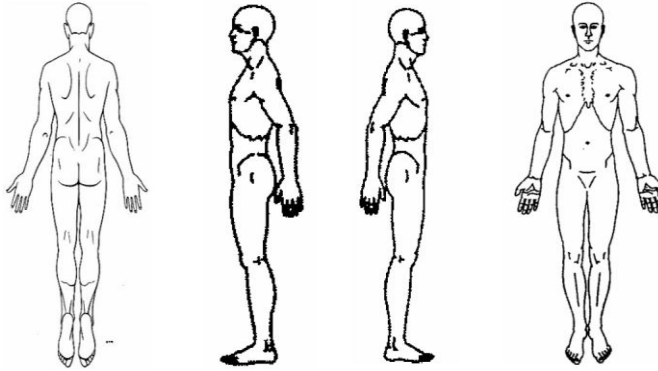
Patient Name: _____

Account #: _____

PATIENT HISTORY

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



	1 st Complaint	2 nd Complaint	3 rd Complaint	4 th Complaint	5 th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10 1 = mild 5 = moderate 10 = severe Rate your pain levels:	Current:	Current:	Current:	Current:	Current:
	Average:	Average:	Average:	Average:	Average:
	At Best:	At Best:	At Best:	At Best:	At Best:
	At Worst:	At Worst:	At Worst:	At Worst:	At Worst:
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____
How long does it last?	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant
What makes it better?					
What makes it worse?					

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

- | | | | | | | | |
|----------|-----|----------|-----|----------|-----|------------|-----|
| Walking | Y N | Kneeling | Y N | Grooming | Y N | Driving | Y N |
| Bending | Y N | Sitting | Y N | Standing | Y N | Exercising | Y N |
| Sleeping | Y N | Lifting | Y N | Running | 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: _____

Doctors Signature: _____ 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). Do not 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
- Loss of Memory
- Nervousness
- Sweaty Palms
- Speech Difficulty
- Anxiety
- Depression
- Irritability

Anyone in your family have or had:

- stroke arthritis
- cancer hypertension
- heart problems diabetes

Please circle if you have any of the following:

- | | |
|---|--|
| <input type="checkbox"/> General | Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity |
| <input type="checkbox"/> Skin | Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes |
| <input type="checkbox"/> Head | Trauma, headaches, dizziness, light headed |
| <input type="checkbox"/> Eyes | Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge |
| <input type="checkbox"/> Nose | Rhinorrhea, Epistaxis, allergies, airway obstruction |
| <input type="checkbox"/> Mouth & Throat | Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat |
| <input type="checkbox"/> Neck | Stiffness, lumps / swelling / masses, pain |
| <input type="checkbox"/> Lungs | Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats |
| <input type="checkbox"/> Cardiac | Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope |
| <input type="checkbox"/> Vascular | Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever |
| <input type="checkbox"/> Breasts | Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling |
| <input type="checkbox"/> Gastrointestinal | Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, hematures, sexually transmitted diseases, dyspareunia, scrotal swelling |
| <input type="checkbox"/> Genitourinary | Polyuria nocturia, oliguria, dysuria, urgency, incontinence, urine color change |
| <input type="checkbox"/> Endocrine | Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric |
| <input type="checkbox"/> Hematopoietic | Anemia, abdominal bleeding, lymph node enlargement/pain |
| <input type="checkbox"/> Musculoskeletal | Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weakness, atrophy |
| <input type="checkbox"/> Neurological | Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, stasis, loss of balance, numbness, parasthesia |
| <input type="checkbox"/> 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).

Problems List

Dr. Name/Facility	Problem TXT received	When to When
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____