

PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: _____ ACCT # _____
 NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____
 DATE OF BIRTH: _____ AGE: _____ GENDER: _____
 YOUR ADDRESS: _____ CITY: _____
 STATE: _____ ZIP: _____ SS #: _____ HOME #: _____
 YOUR OCCUPATION: _____ WK #: _____
 EMERGENCY CONTACT _____ PH #: _____ CELL #: _____

MARITAL STATUS **S M W D**

HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? Yes No

HAVE YOU EVER HAD CHIROPRACTIC CARE? Yes No HOW LONG HAS IT BEEN? _____

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? _____

FOR DOCTOR'S USE ONLY

GENERAL

INJURY TYPE:

NDRA

DRUG ALLERGIES:

SEE MEDS ADDENDUM

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

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.

	FOR DOCTORS'S USE ONLY	
	DR. REVIEWED	SYSTEMS SYMPTOMS
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:

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

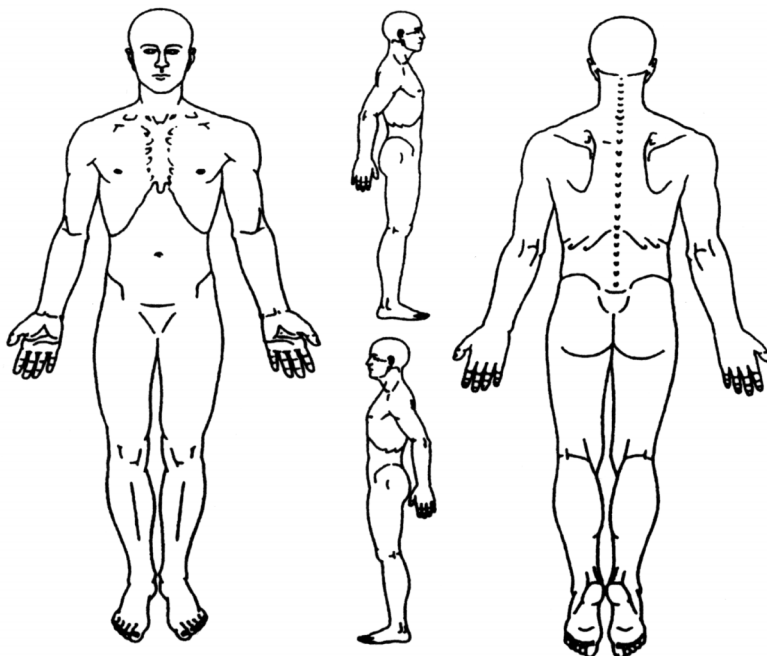
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

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



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: ____/____/____

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? _____