PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE:______________________ CELL PROVIDER:______________________

NAME:______________________ DOB:____/____/____ PH #:______________________

ADDRESS:______________________ CITY:______________ STATE:________ ZIP:__________

EMAIL:______________________ SS#:______________________

YOUR OCCUPATION:______________________

MARITAL STATUS: **S M W D** SPOUSE NAME:______________________

EMERGENCY CONTACT:______________________ PH #:______________________

DO YOU HAVE ANY CHILDREN?______________ WHAT ARE THEIR AGES?______________

HAVE YOU EVER HAD CHIROPRACTIC CARE IN THE PAST? ☐ YES ☐ NO HOW LONG HAS IT BEEN?__________

THE PURPOSE OR REASON FOR THIS APPOINTMENT?______________________

DO YOU DRINK? **Y / N** HOW OFTEN?______________________
DO YOU SMOKE? **Y / N** HOW OFTEN?______________________
DO YOU EXERCISE? **Y / N** HOW OFTEN?______________________

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 Circulatory Problems
Y N *Rheumatoid Arthritis
Y N Seizures/Convulsions
Y N A Congenital Disease
Y N Excessive Bleeding
Y N High/Low Blood Pressure
Y N *Diabetes
Y N *Osteoarthritis
Y N Epilepsy
Y N Pacemaker
Y N Strokes
Y N *Cancer
Y N Ulcers
Y N Ruptures
Y N Coughing Blood
Y N Eating Disorder
Y N Alcoholism
Y N Drug Addiction
Y N HIV Positive
Y N Gall Bladder
Y N *Head Problems
Y N Depression
Y N Tumors

☐ **Nothing New Since Last Completion**

*Explanation:______________________
____

WHEN WAS YOUR LAST PHYSICAL EXAM?______________________
PREVIOUS ACCIDENT?__________ TYPE/YEAR______________________
DO YOU HAVE HEALTH INSURANCE? YES NO NAME OF INSURANCE:______________________

MEDICATION LIST

(FOR THIS CONDITION ONLY)

NAMES OF MEDICATION RX or OTC	DATE STARTED	WHO PRESCRIBED DR /SELF
		D / S
		D / S
		D / S
		D / S

FOR DOCTORS USE ONLY

☐ GENERAL

INJURY TYPE:

☐ NDRA

DRUG ALLERGIES

☐ SEE MEDS ADDENDUM

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)

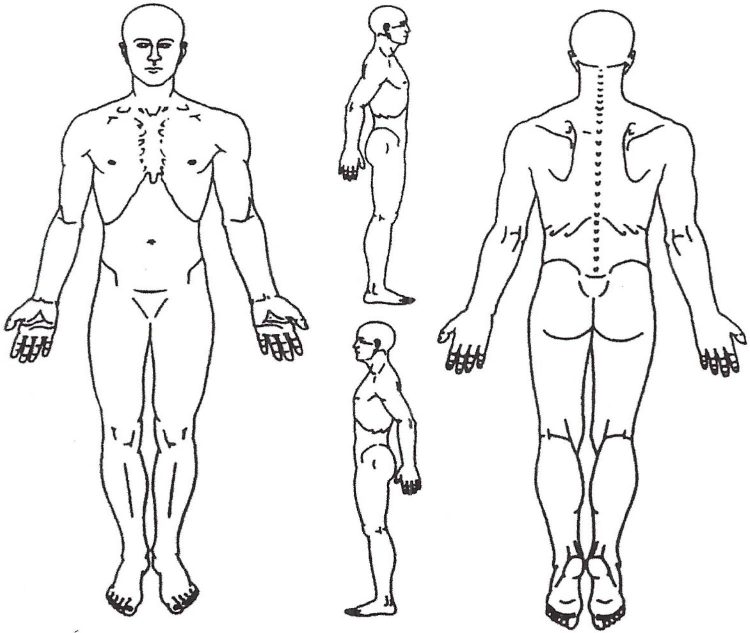
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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: ____/____/____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

- ❑ Car ❑ Station Wagon
- ❑ Van ❑ Pickup Truck
- ❑ Large Truck ❑ Bus
- Other________________

2. Your position in vehicle

- ❑ Driver ❑ Front Passenger
- ❑ Left Rear Passenger
- ❑ Right Rear Passenger
- Other________________

3. What was your vehicle doing at the time of the accident?

- ❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
- ❑ Making a right turn ❑ Making a left turn ❑ Parking
- ❑ Proceeding along ❑ Slowing down ❑ Accelerating
- Other________________

4. Time/Speed/Damage

Time of accident__________

Your vehicle's speed: ___________mph

Their vehicle's speed: ___________mph

Damage to your vehicle

❑ Mild ❑ Moderate ❑ Totaled

5. Details of Accident

Visibility at time of accident

❑ Poor ❑ Fair ❑ Good

Who hit who/what?

❑ You hit other vehicle

❑ Other vehicle hit you

You hit...(object)

____

6. Road conditions

Road conditions at time of accident

❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact

- ❑ Head-On ❑ Left Front ❑ Right Front
- ❑ Rear-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

- Did you see the accident coming: Yes❑❑ No
- Were you braced for the impact? Yes❑❑ No
- Did you have a seat belt on? Yes❑❑ No
- Did you have a shoulder harness on? Yes❑❑ No

Does your vehicle have headrests? Yes❑❑ No

What was the position of your headrest at the time of the impact?

❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck

What was the direction of your head at the time of the impact?

❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑❑ No** Did passenger side airbags deploy? **Yes❑❑ No** Did side airbags deploy? **Yes❑❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑❑ No**

If yes, describe:________________

Did you lose consciousness during the injury? **Yes❑❑ No**

If yes, for how long? ________________

Your vehicle's estimated damage? ________________

Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled

Did police show up at the scene? **Yes❑❑ No**

Was an accident report filled out? **Yes❑❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:

- ❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
- ❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
- ❑ Neck stiffness ❑ Confusion ❑ Nervousness ❑ Diarrhea
- ❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
- ❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
- ❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest Pain
- ❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems

Others:________________

11. Emergency Room?

Where did you go after the accident?

❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor

How did you get there?

❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police

Were X-rays done? Yes❑❑ No **Was lab work done?** Yes❑❑ No

Body parts X-rayed?________________

What lab work?________________

The X-rays revealed: ________________

Treatments: ❑ Cervical Collar ❑ Ice **Other:** ________________

Medications:________________

Follow-up instructions: ________________

____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office

1. Dr. ________________ First visit date: ___/___/____

Specialty:________________ X-rays done? **Yes❑❑ No**

Types of treatments received:________________

How many treatments received?____ Currently treating? **Yes❑❑ No**

Did treatments benefit you? **Yes❑❑ No**

Last visit date: ___/___/___

2. Dr. ________________ First visit date: ___/___/____

Types of treatments received:________________

How many treatments received?____ Currently treating: **Yes❑❑ No**

Did treatments benefit you? **Yes❑❑ No**

Last visit date: ___/___/___

Patient Sign & Date:________________________ **Date:**________________

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