

# 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 *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          |

**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
		<b>D / S</b>
		<b>D / S</b>
		<b>D / S</b>
		<b>D / S</b>

#### 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

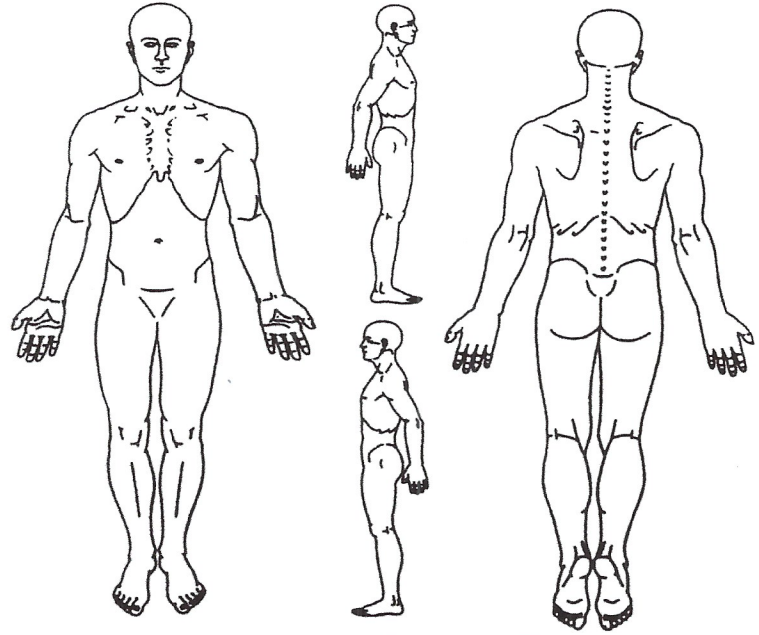
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

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



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? \_\_\_\_\_