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
		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)

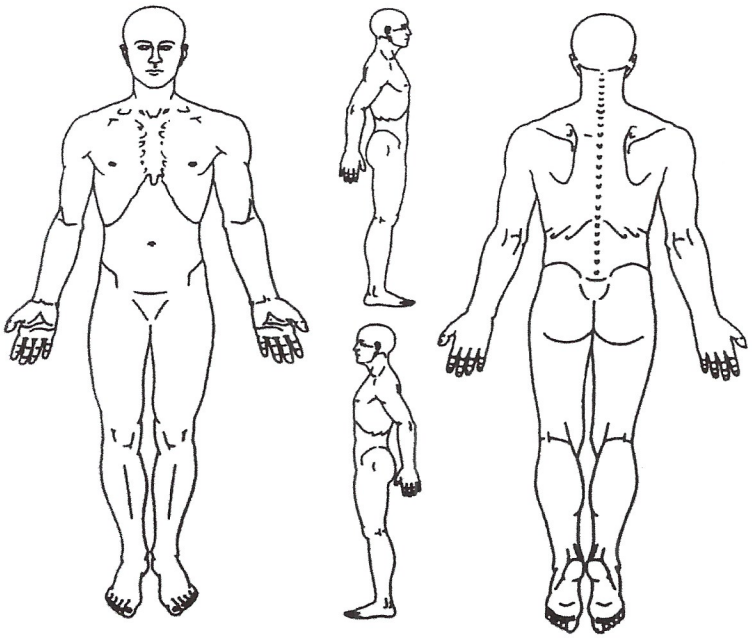
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

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: ____/____/____

Patient Basic Information

Personal Information:

Last Name:	First Name:		Mid. Init.:
Address:	City, State, Zip:		
Home Phone:	Work Phone:	Social Security No.:	
Date of Birth:	Date of Injury/Onset:		
Dominant Hand: ❑ Right ❑ Left ❑ Both			
Insurance Information: Policy Holder (if different than patient):		Policy No.:	

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. Your condition during and immediately after injury/onset

Enter the details of your condition during and immediately after your injury/onset.

Patient Sign & Date:_____ **Date:**_____