MR#: ______________

PATIENT APPLICATION FOR TREATMENT

NAME: ______________ TODAY'S DATE: ______________

WHAT NAME (NICKNAME) WOULD YOU LIKE TO BE CALLED? ______________

HOW WERE YOU REFERRED TO OUR OFFICE? ______________

DATE OF BIRTH: ______________ AGE: ______ M / F HT. ____ WT. ____

YOUR ADDRESS: ______________ APT # ____ HOME PHONE: ______________

CITY/STATE/ZIP: ______________ MOBILE PHONE: ______________

YOUR OCCUPATION: ______________ WORK PHONE: ______________

EMPLOYER: ______________ EMAIL (please print): ______________

ADDRESS/LOCATION: ______________ CITY/STATE/ZIP: ______________

SPOUSE'S NAME: ______________ HOW MANY CHILDREN DO YOU HAVE? ______________

EMPLOYER: ______________ WHAT ARE THEIR AGES? ______________

OCCUPATION: ______________

HAVE YOU EVER HAD CHIROPRACTIC CARE? ☐ YES ☐ NO HOW LONG HAS IT BEEN? ______________

DO YOU SMOKE? ☐ YES ☐ NO HOW MUCH? ______________

DO YOU EXERCISE? ☐ YES ☐ NO HOW OFTEN? ______________ TYPE: ______________

DRUG ALLERGIES: ______________

OTHER ALLERGIES: ______________

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND?

☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DETAILS: ______________

DID (DO) YOU PLAY ANY SPORTS? ☐ YES ☐ NO

ANY MEMORABLE HITS EVEN IF NO PAIN? (DETAILS) ______________

____

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INJURY TYPE:

TX'D BY:

HAVE YOU BROKEN ANY BONES, EVEN HANDS or FEET? ☐ YES ☐ NO

(DETAILS) ______________

HAVE YOU HAD ANY BAD SLIPS or FALLS? ☐ YES ☐ NO

(DETAILS) ______________

HAVE YOU HAD ANY SURGERIES? ☐ YES ☐ NO

(DETAILS) ______________

TYPES OF PHYSICAL or STRESSFUL JOBS? ☐ YES ☐ NO

(DETAILS) ______________

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☐ REVIEWED EXTERNAL H P

☐ RELEASE RECORDS H P

☐ REQUEST RECORDS H P

EXTERNAL DX'D: ______________

____

DISABILITIES:

IMPAIRMENTS:

ORDERS:

☐ STAT ☐ PENDING EXAM

DIFFERENTIAL DX ______________

PROBLEMS LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

LAST PHYSICAL EXAM DATE: ______________

PATIENT HISTORY

WHAT IS YOUR CHIEF COMPLAINT? *(please circle):* ***HEAD, NECK, SHOULDER(S), ARM(S), MIDDLE BACK, LOWER BACK, HIP(S), LEG(S), OTHER:*** ______

WHEN DID THIS PROBLEM FIRST BEGIN? ______

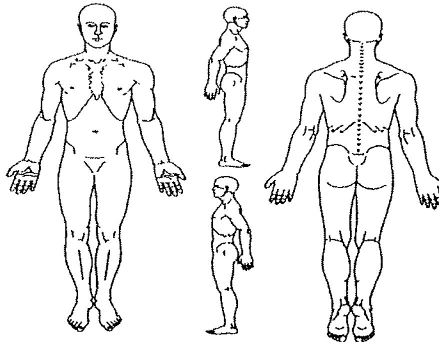
WHEN DO YOU NOTICE IT MOST? ☐ AM ☐ PM

HAVE YOU EVER HAD THIS PROBLEM IN THE PAST? ☐ YES ☐ NO

HAVE YOU LOST TIME FROM WORK BECAUSE OF IT? ☐ YES ☐ NO
IF YES, PLEASE LIST DATES: ______

ON THE DIAGRAM BELOW, PLEASE SHOW WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS RELATED TO YOUR COMPLAINT. USE THE LETTERS TO REPRESENT WHAT TYPE OF PAIN.

- **A**: ACHING
- **B**: BURNING SENSATION
- **C**: CRAMPING
- **D**: DULL / THROBBING
- **M**: MUSCLE
- **N**: NUMBNESS
- **S**: SHARP
- **T**: TINGLING
- **C**: COLD
- **H**: HOT



WHAT ARE SOME OF THE THINGS YOU DO WHICH MAKE THIS FEEL BETTER? *(please circle):* ***ICE, HEAT, REST, MASSAGE, LYING DOWN, STANDING, SITTING, PAIN MEDS, OTHER:*** ______

PROVOCATIVE: SUBLUXATIONS CAN BE AGGRAVATED BY CERTAIN ACTIVITIES AND INCREASE PAIN. WHAT ARE SOME OF THE THINGS YOU DO WHICH MAKE YOU FEEL WORSE? *(please circle):* ***COMPUTER WORK, TURNING HEAD, SITTING, STANDING, BENDING, LIFTING, CLIMBING STAIRS, WALKING, REACHING, LAYING DOWN, OTHER:*** ______

HOW MANY MINUTES/POUNDS BEFORE IT WORSENS? ______MINUTES ______POUNDS

RADIATING: THE MORE SEVERE THE NERVES ARE CRUSHED, THE FURTHER THE PAIN TRAVELS FROM THE SOURCE OF THE PROBLEM. DOES THE PAIN RADIATE TO ANY OTHER AREA? *(please circle):* ***HEAD, SHOULDER, ARM, HIP, LEG, OTHER:*** ______

I AM EXPERIENCING PAIN/DISCOMFORT IN THE FOLLOWING EXTREMITIES: *(please circle):* ***SHOULDER, ELBOW, WRIST, RIB CAGE, HIP, KNEE, JAW, OTHER*** ______

WHAT OTHER PROBLEMS DO YOU HAVE THAT YOU FEEL MAY BE RELATED TO YOUR PRIMARY PRESENTING PROBLEM? ______

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AREA/1° Csp Tsp Lsp Ssp Psp ______

☐ ACUTE EXACERBATION
☐ SUDDEN ONSET
☐ PROGRESSIVE W/O OBVIOUS CAUSE
☐ PERSISTENT ☐ RECURRENT

RELATIONSHIP(S) TO FACTORS: ______

☐ REFERRED
☐ UNRELATED
☐ CONSTANT
☐ INTERMITTENT

SYSTEM(S): ______

SEVERITY:
☐ MILD
☐ MODERATE
☐ MODERATELY SEVERE

EPISODIC PRESENTATION:
A______ SA______ CHRONIC______

SYMPTOM STATUS:
☐ TASK RELATED______
☐ DECREASING ______
☐ INCREASING______

EFFECTS:
SOCIAL______
WORK______
PERSONAL______

IF WE CAN HELP, WHAT DO YOU WISH TO DO THAT IS NOW DIFFICULT OR IMPOSSIBLE? ______

WHAT ARE YOUR HOBBIES? ______

DOES ANY MEMBER OF YOUR FAMILY SUFFER FROM THE SAME OR SIMILAR PROBLEMS? ☐ YES ☐ NO *(please circle):* ***DAUGHTER, SON, MOTHER, FATHER, SISTER, BROTHER, GRANDMOTHER, GRANDFATHER, OTHER:*** ______

HAVE THEY EVER BEEN TREATED FOR THEIR CONDITION? ☐YES ☐ NO ☐Don't Know

EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING? ***(please circle)*** **YES NO FAMILY**

Y N F CIRCULATORY PROBLEMS
Y N F **RHEUMATOID ARTHRITIS**
Y N F SEIZURES/CONVULSIONS
Y N F A CONGENITAL DISEASE
Y N F EXCESSIVE BLEEDING
Y N F HIGH/LOW BLOOD PRESSURE
Y N F **DIABETES**
Y N PAST SMOKER

Y N F OSTEOARTHRITIS
Y N F EPILEPSY
Y N F PACEMAKER
Y N F **STROKES**
Y N F **CANCER**
Y N F ULCERS
Y N F RUPTURES
Y N F COUGHING BLOOD

Y N F EATING DISORDER
Y N F ALCOHOLISM
Y N F DRUG ADDICTION
Y N F HIV POSITIVE
Y N F GALL BLADDER
Y N F **HEAD PROBLEMS**
Y N F DEPRESSION
Y N F TUMORS

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTORS TO KNOW? ______