

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: _____

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

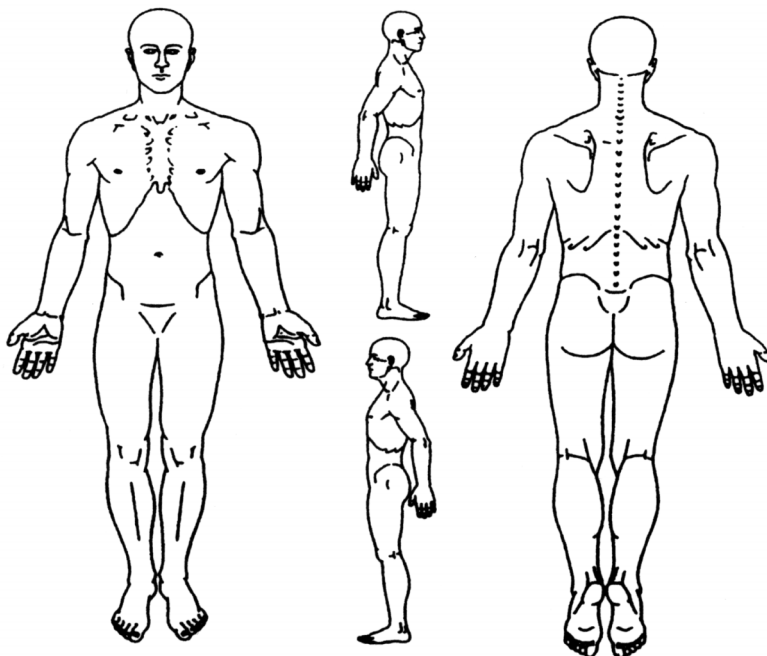
3. On the scale below please **circle** the **percentage of time** you experience your **main complaint**:

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 _____

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? _____

Signature: _____

Date: ___ / ___ / ___