



## Patient Application For Treatment

Today's Date: \_\_\_\_\_ E-mail: \_\_\_\_\_ Gender: M F  
 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Your Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ SS #: \_\_\_\_\_ Home #: \_\_\_\_\_  
 Name of Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Martial Status: S M W D Referred By: \_\_\_\_\_ Cell #: \_\_\_\_\_  
 How Many Children Do You Have? \_\_\_\_\_ What Are Their Ages? \_\_\_\_\_  
 Have You Or Any Other Members of Your Family Received Chiropractic Care? ? Yes ? No  
 How Long Has It Been? \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Who Is Responsible For Your Bill? ? Self ? Spouse ? Worker's Compensation ? Medicaid  
 ? Medicare ? Auto Insurance ? Personal Health Insurance ? Other: \_\_\_\_\_  
 Purpose Or Reason For Today's Appointment? \_\_\_\_\_  
 How Often Do You Drink Alcoholic Beverages? \_\_\_\_\_  
 Do You Smoke? ? Yes ? No How Much? \_\_\_\_\_  
 Do You Exercise? ? Yes ? No How Much? \_\_\_\_\_ Type? \_\_\_\_\_  
 Do You have Any Allergies? Yes No 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 Epilepsy	Y N Eating Disorder
Y N Circulatory Problems	Y N Pacemaker	Y N Alcoholism
Y N *Rheumatoid Arthritis	Y N Strokes	Y N Drug Addition
Y N Seizures/Convulsions	Y N *Cancer	Y N HIV Positive
Y N A Congenital Disease	Y N Ulcers	Y N Gall Bladder
Y N Excessive Bleeding	Y N Ruptures	Y N *Head Problems
Y N High/Low Blood Pressure	Y N Coughing Blood	Y N Depression
Y N *Diabetes	Y N Osteoarthritis	Y N Tumors

Explain: \_\_\_\_\_

### Medication List

Name of Medications	Name of Vitamins	Date Started	Date Stopped

### FOR DOCTOR'S USE ONLY:

O:  
 MI:  
 R:  
 Site:  
 AS/S:  
 H:  
 Past Image:  
 Past Care:  
 Tra:  
 Occup:  
 Diet:  
 Sleep:  
 Stress:

# Systems Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Do not leave any blanks.

- High Blood Pressure
- Dizziness / Fainting
- Insomnia
- Low Resistance
- Tension
- Confusion
- Fatigue
- Ulcers
- Eye/Vision Problems
- Ear/Hearing Problems
- Difficulty Breathing
- Heart Problems
- Loss of Bladder Control
- Constipation
- Diarrhea
- Digestion Problems
- Nausea
- Female Problems
- Prostate Problems
- Diabetes
- Hands / Feet Cold
- Loss of Memory
- Nervousness
- Sweaty Palms
- Speech Difficulty
- Anxiety
- Depression
- Irritability

**Anyone in your family have or had:**

- stroke                       arthritis
- cancer                         hypertension
- heart problems
- diabetes

**For Doctors Use Only:**

- General                      Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
- Skin                            Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
- Head                            Trauma, headaches, dizziness, light headed
- Eyes                            Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
- Nose                            Rhinorrhea, Epistaxis, allergies, airway obstruction
- Mouth & Throat            Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
- Neck                            Stiffness, lumps / swelling / masses, pain
- Lungs                            Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
- Cardiac                        Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
- Vascular                        Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
- Breasts                        Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
- Gastrointestinal            Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemesis, stool color changes, hematuries, sexually transmitted diseases, dyspareunia, scrotal swelling
- Genitourinary                Polyuria nocturia, oliguria, dysuria, urgency, incontinence, urine color change
- Endocrine                      Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation, history, pregnancy history, dysmenorrheal, premenstrual syndrome, climacteric
- Hematopoietic                Anemia, abdominal bleeding, lymph node enlargement,/pain
- Musculoskeletal            Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weakness, atrophy
- Neurological                Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, parasthesia
- Psychological                Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

Dr. Name/Facility	Problem	Problems List TXT received	When to When
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

<b>For Dr. Use Only:</b>		
? Reviewed External	H	P
? Release Records	H	P
? Request Records	H	P

External DX'D:  
Disabilities:  
Impairments:

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Acct# \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Account# \_\_\_\_\_

## PATIENT HISTORY

Complaint #1: \_\_\_\_\_ When did it start? \_\_\_\_\_

Circle the current **pain level** of your complaint: 

0	1	2	3	4	5	6	7	8	9	10
Mild				Moderate						Severe

Circle the **percentage** of time you experience the complaint: 

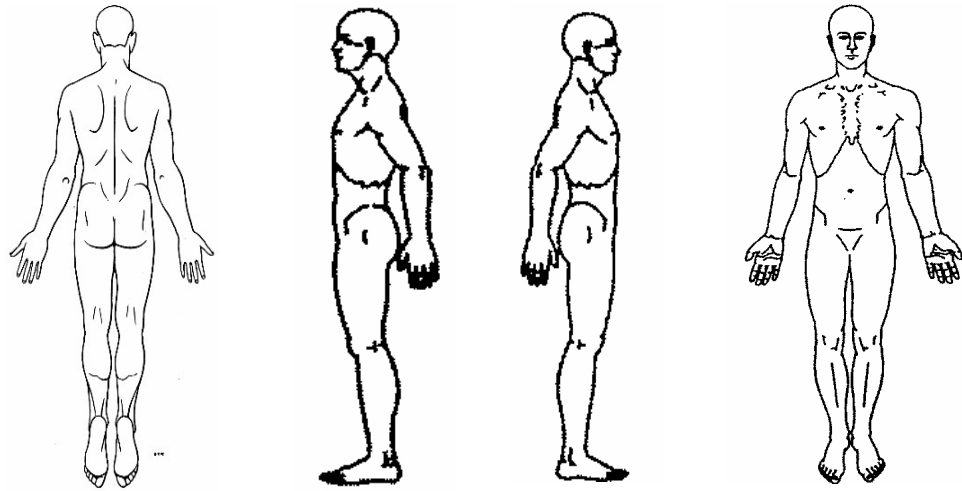
0	10	20	30	40	50	60	70	80	90	100	%
	Occasional		Intermittent				Frequent			Constant	

When do you feel it most? ? AM ? PM When present, how long does the complaint last? \_\_\_\_\_min \_\_\_\_\_Hrs

What makes you feel better? \_\_\_\_\_ What make if feel worse? \_\_\_\_\_

Using the letters below, please show **where** you are experiencing **all** of your complaints on the diagram:

- A. Ache
- B. Burning
- C. Cramping
- D. Dull Pain
- F. Stiffness
- N. Numbness
- R. Throbbing
- S. Soreness
- T. Tingling
- X. Sharp Pain



<b>Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)</b>			
Walking	? Y ? N	Bending	? Y ? N
Sleeping	? Y ? N	Kneeling	? Y ? N
Sitting	? Y ? N	Lifting Children	? Y ? N
Personal Grooming	? Y ? N	Lifting Objects	? Y ? N
Standing	? Y ? N	Running	? Y ? N
Driving	? Y ? N	Exercising	? Y ? N
Housework	? Y ? N		

1. Have you ever had the condition(s) in the past? ? Yes ? No If yes, please indicate if any treatment was received and what type of treatment: ? Hospitalization ? Chiropractic care ? Medical doctor / specialty provider ? None
2. Have you ever lost time from work due to your condition(s)? ? Yes ? No If Yes, dates? \_\_\_\_\_
3. Are you pregnant? ? Yes ? No
4. What was the first day of your last menstrual cycle? \_\_\_\_\_
5. Number of pregnancies? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Physician Initials:** \_\_\_\_\_