

Patient Application for Treatment

*** Please notify receptionist if your conditions are due to an auto or work related accident

Last Name _____ First _____ Middle In. _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

E-mail _____ Spouse's Name _____

Occupation _____ Employer _____ Hours per week worked _____

Social Security # _____ Age _____ D.O.B. ____/____/____ Male Female Married Single

Emergency Contact _____ Ph.# _____ Relationship: _____

Family Doctor _____ Phone # _____ Last Exam Date _____

Previous Chiropractic Care (doctor, date last seen, results) _____

Name/Age of your Children _____

If you were referred to our office, whom may we thank? _____

Date and explanation of last accident of any kind? _____

List Past Surgeries with date: _____

Medication List: Give the name and intended purpose of all medications and vitamins you are currently taking: _____

Alcohol	<input type="checkbox"/> Y / <input type="checkbox"/> N	Drinks per day/ wk?	Tobacco	<input type="checkbox"/> Y / <input type="checkbox"/> N	Times per day?
Caffeine	<input type="checkbox"/> Y / <input type="checkbox"/> N	Drinks per day?	Exercise	<input type="checkbox"/> Y / <input type="checkbox"/> N	Hours per week?
Water	<input type="checkbox"/> Y / <input type="checkbox"/> N	Glasses per day?	Chocolate	<input type="checkbox"/> Y / <input type="checkbox"/> N	Times per day/ wk?

Insurance: Complete only if patient is not the primary insured policyholder

Insured's name: _____ **Insured's date of birth** _____ **Insured's SS#** _____

Financial Release and Assignment:

Payment is expected on the date that services are rendered. Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility. I understand any outstanding accounts beyond 90 days may result in a 25% finance charge per month. If the account is sent to collections, any fees associated with the collection of charges will also be billed to the patient (according to Collection Agency fee amounts). I authorize the release of any information necessary to process my insurance claims and request payment be sent directly to my physicians.

Patient/Parent/Advocate Signature: _____ Date: _____

X-ray Consent: The purpose of the x-ray examination to be performed is to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. I thus must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I understand that seeking advice from another healthcare provider will likely not interfere with the subluxation correction care provided by this office. I fully understand the above and consent to chiropractic spinal x-rays.

Patient/Parent/Advocate Signature: _____ Date: _____

WOMEN ONLY - Pregnancy Release: This is to certify that to the best of my ability I am not pregnant and I give my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child. Date of last menstrual period: _____

Patient/Parent/Advocate Signature: _____ Date: _____

Patient History: (filled out by the patient)

What is your main complaint(s)? _____ How long has it been present? _____

Other doctors seen for this condition: Yes No Who and Where? _____

Type of Treatment(s) _____ Results _____

Is condition: Job related Auto Accident Home Injury Fall Unknown Other _____

For this condition have you had: X-Rays MRI CT Blood Work Other _____

Circle the INTENSITY of your PAIN when present (0=no pain, 10=severe pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mark the FREQUENCY of your PAIN: Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)

Describe the Pain (mark all that apply): Dull, Sharp, Ache, Throb, Burning, Numb, Tingling, Cramping, Spasm, Shooting

Does the pain move into other body parts: Head Neck Shoulder Arm/Hand Hip/Buttocks Leg/Foot _____

When do you notice the complaint most? AM PM

What makes it feel better? _____

What makes it feel worse? _____

Have you lost time from work because of it? Yes No

Do you have pain, difficulty, and/or change in interest any of the below activities due to main complaint(s) (check all that apply):

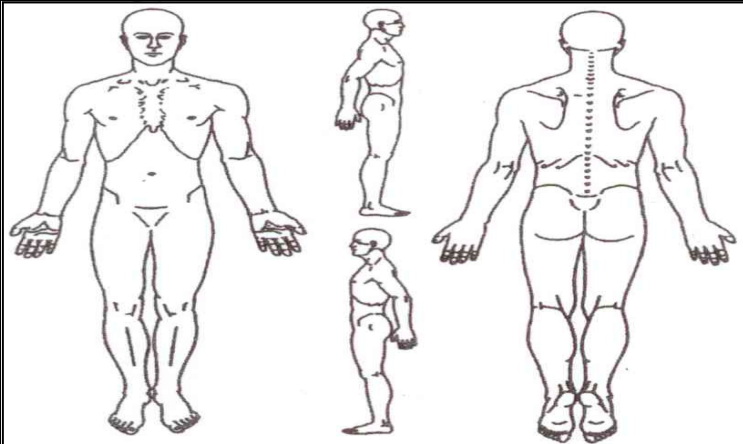
- personal care lifting reading concentrating work
- driving sleeping recreational activities walking
- sitting standing social activities

_____ On a scale of 1-10, how much do you want to get rid of your current problem(s)?

Assuming we can help, are there any constraints that would prevent you from following the doctor's recommended treatment plan?

- No Yes... Work Schedule / Time Transportation Cost

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters: **A**=Ache/dull pain, **B**=Burning pain, **C**=Cramping, **T**=Throbbing, **N**=Numbness/Tingling.



Have you ever suffered from or been diagnosed as having (check all that apply):

- | | | | |
|---|--|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Neck Pain (R - L) <input type="checkbox"/> Arm Pain (R - L) <input type="checkbox"/> Arm Numbness (R - L) <input type="checkbox"/> Hand Pain (R - L) <input type="checkbox"/> Hand Numbness (R - L) <input type="checkbox"/> Shoulder pain (R - L) <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Low back pain <input type="checkbox"/> Buttock Pain (R - L) <input type="checkbox"/> Hip Joint Pain (R - L) <input type="checkbox"/> Pain down leg (R - L) <input type="checkbox"/> Leg numbness (R - L) <input type="checkbox"/> Foot Pain (R - L) <input type="checkbox"/> Foot numbness (R - L) <input type="checkbox"/> Under stress | <ul style="list-style-type: none"> <input type="checkbox"/> Fractured bones* <input type="checkbox"/> Auto Accidents <input type="checkbox"/> 0-1 years ago <input type="checkbox"/> 1-5 years ago <input type="checkbox"/> 5+ years ago <input type="checkbox"/> Other accidents/falls* <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy* <input type="checkbox"/> Skin problems* <input type="checkbox"/> Cancer *(explain) <input type="checkbox"/> Frequent colds/flu <input type="checkbox"/> Depression <input type="checkbox"/> Anemia <input type="checkbox"/> Allergies*/ Sinus <input type="checkbox"/> Learning disability* <input type="checkbox"/> Mood changes* | <ul style="list-style-type: none"> <input type="checkbox"/> Congenital Disease* <input type="checkbox"/> Tumors* <input type="checkbox"/> Jaw pain / clicking <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in ears (R - L) <input type="checkbox"/> Hearing loss <input type="checkbox"/> Blurred/double vision <input type="checkbox"/> Pain with cough/sneeze <input type="checkbox"/> Coughing blood <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart problems <input type="checkbox"/> Heartburn / GERD <input type="checkbox"/> Stroke <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Varicose veins <input type="checkbox"/> Eating Disorders* <input type="checkbox"/> Irritability | <ul style="list-style-type: none"> <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Trouble concentrating <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Digestive problems* <input type="checkbox"/> Ulcers <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bedwetting <input type="checkbox"/> Ear infections <input type="checkbox"/> AIDS/HIV* <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Addiction* |
|---|--|---|---|

*Explain any checked asterisks above: _____

I consent that I, the patient, filled out this page: Patient/Parent/Advocate Signature _____