APPLICATION FOR TREATMENT

Name: ____ Date:________________

Doctor referred to: _______________________ Referred by:_____________________

1. REASON FOR VISIT:

List your chief complaint:

____

____

____

When did this episode begin?_________________________

How did it occur? Gradually Suddenly

Describe: ____

____

Is it: Worse Better Intermittent Constant Daily

Have you had this or similar problems in the past? Yes No

If yes, when?___________________________________

When is it worse? AM PM Nighttime

With what does it interfere? Work Sleep Daily routine

Other:_________________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Do you have pain/numbness in the arms, legs, hands or feet?

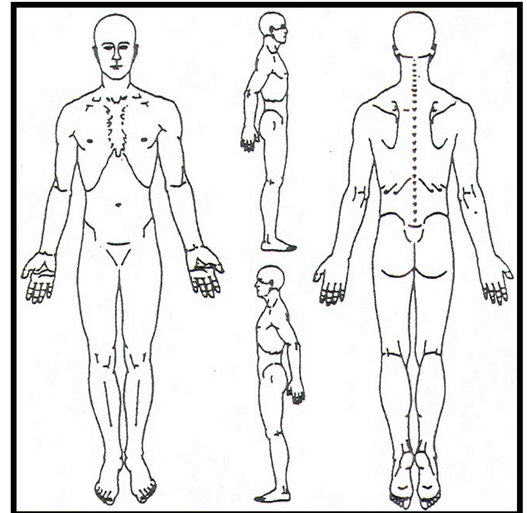
Yes No Where and what type? __________________

Have you seen any other doctors for this problem? Yes No

If yes, doctor's name:______________________________

DRAW PAIN AREAS BELOW 🡇

XXX = PAIN // = NUMBNESS



What type of physician? Chiropractic Medical Other Most recent visit date: _______________

What did they recommend? ____

On a scale of 0 to 10, with 10 = extreme pain, and 0 = no pain, rate your average pain level: _______________

2. PAST HEALTH HISTORY:

Drugs you now take: Pain killers Muscle relaxers Blood pressure Birth control Other: ________

List all surgeries you have had and when: ____

____

Prior Injuries (please circle location and describe type of injury):

Shoulder / Arm / Elbow / Wrist / Hand / Finger / Hip / Leg / Knee / Ankle / Foot / Toe

Head / Spine / Pelvis

Describe injuries: ____

____

Which (if any) of the above injuries still bother you? _________________________________

____

Have you ever experienced loss of consciousness? If so, describe: ___________________________

____

Last auto accident: Past year Past five years Over five years Never

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3. FAMILY HEALTH HISTORY

Many health problems have familial tendencies. Information about family members will give us a better picture of your total health.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

4. YOUR HEALTH HISTORY   C = Current, P = Past

General
- C P Allergy
- C P Convulsions
- C P Dizziness
- C P Fainting
- C P Headache

Muscle & Joint
- C P Arthritis
- C P Bursitis
- C P Low back pain
- C P Neck pain/stiffness
- C P Pain between shoulders
- C P Spinal Curvature

Eyes, Ears, Nose & Throat
- C P Deafness
- C P Earache
- C P Failing Vision
- C P Nosebleeds
- C P Sinus infections
- C P Strep throat

General-Intestinal
- C P Colon trouble
- C P Constipation
- C P Diarrhea
- C P Gall Bladder trouble
- C P Hemorrhoids
- C P Hernia
- C P Liver trouble
- C P Nausea

Respiratory
- C P Asthma
- C P Chest Pain
- C P Chronic cough
- C P Spitting up blood

Pain or numbness in
- C P Shoulders/Arms
- C P Elbows/Hands
- C P Hips/Legs
- C P Ankles/Knees/Feet

Skin problems
- C P Bruise easily
- C P Hives or allergy
- C P Skin rash

Other
- C P Diabetes
- C P Alcoholism
- C P Anemia
- C P Cancer
- C P Measles
- C P Stroke
- C P Rheumatic fever
- C P Sex trans disease
- C P Gout
- C P Mumps
- C P Polio

Cardio-Vascular
- C P Hardening of arteries
- C P High blood pressure
- C P Low blood pressure
- C P Rapid/slow heart beat
- C P Swelling of ankles

Genital-Urinary
- C P Bed-wetting
- C P Frequent urination flow
- C P Kidney infection
- C P Painful urination
- C P Prostate trouble

For Women Only
- C P Cramps or backaches
- C P Excessive menstrual
- C P Irregular cycle
- C P Lumps in breast
- C P Post-menopausal

Psycho-Social
- C P Depression
- C P Anxiety
- C P Sleep disturbances
- C P Chronic fatigue
- C P Divorce
- C P Death
- C P Family problems
- C P Economic
- C P Drugs/Alcohol
- C P Change in job status
- C P Work problems

Check the appropriate box below:

Meals skipped:	Coffee-Daily	Alcoholic beverages		Personal satisfaction w/diet
Daily no.______	1-2 daily	1-2 daily	1-2 weekly	Highly satisfied
	3-4 daily	3-4 daily	3-4 weekly	Satisfied
Weekly no______	More	More		Highly unsatisfied

IN CASE OF EMERGENCY: (Name of friend or relative not living at home)

Name: ________________________________ **Relationship:** ____________________

Address:____________________________________**Phone#:**__________________

Fees are payable at the time x-rays, examination, and treatment(s) are received unless other arrangements are made in advance. X-rays remain the property of this clinic. I understand the above and hereby authorize the doctor to examine and treat my condition as he deems appropriate through the use of any combination of radiographs, manipulation (inclusive of my spine and extremities), therapy, rehabilitative exercises and acupuncture.

Patient Name (Legal Guardian):_________________________ **Date:**___________________

PATIENT INFORMATION:

First Name: ______________________________ M.I. _________ Last Name: ____________________________________

Address: ____

City: _________________________ State: _________ Zip: _______________ Phone: (________) _________________

Sex: M F DOB: _____/______/______ Age: _____ Marital Status: M S D Email: ___________________

Social Security # ___________________________________ Cell: (_________) _______________________

EMPLOYER:

Name: ____ Occupation: _______________________________________

Address: ____

City: ______________________ State: ____________ Zip: ________________ Phone: (________) ________________

INSURANCE CARRIER:

____

Address: ____

City: _________________________ State: ____________ Zip: ____________ Phone: (________) ________________

Policy#: ____ Group#: ____

Insured First Name: _____________________________ M.I. ______ Last Name: _______________________________

Sex: M F DOB: _______/________/_________ SS#: __________-________-__________

IS THIS INJURY A(N): ◻ Auto Accident ◻ On-the-job Injury ◻ Other

Date of injury: ________/_________/_______________ Time of Injury: _________:________ AM PM

Who referred you to our office? ____

Appointment Date: __________/__________/__________ Appointment Time: ___________:_________ AM PM

Chief Complaint: ____

____

____

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