

APPLICATION FOR TREATMENT

Date: _____

Please check the type of care desired: Temporary Relief Lasting Correction

Patient Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone No. _____ Phone at work: _____

Email Address _____ Primary Care Physician _____

Check if you are: Married Single Widowed Divorced Separated

Name of Husband/wife _____ Ages of Children _____

Where are you or husband/wife employed? _____

Your days off: _____ Referred to our office by: _____

Who is responsible for your bill? Self Spouse Employer Insurance Other

How payment will be made:

_____ Cash _____ Workers' Comp _____ Health Insurance

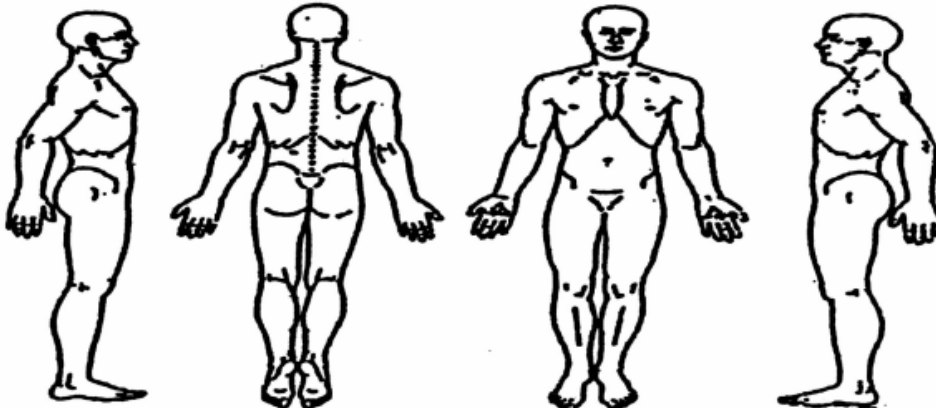
_____ Check _____ Credit card _____ Automobile Ins. Policy

Name of Company and address _____

If you wish to keep up with our updates on facebook please provide us your facebook information

1. Is today's problem caused by: Auto Accident Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time)
- Frequently (51-75% of the time)
- Occasionally (26-50% of the time)
- Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp
- Dull
- Diffuse
- Achy
- Burning
- Shooting
- Stiff
- Numb
- Tingly
- Sharp with motion
- Shooting with motion
- Stabbing with motion
- Electric like with motion
- Other: _____

5. How are your symptoms changing with time?

- Getting Worse
- Staying the Same
- Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

8. How much has the problem interfered with your social activities?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
- ER physician Orthopedist Other: _____
- Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ **Weight** _____ **Date of Birth** _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
- Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

| Past | Present | Past | Present | Past | Present |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss | | |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | | |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | | |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | | |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | | |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue | | |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Muscular In coordination | | |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances | | |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | |

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

20. List all prescription medications you are currently taking:

21. List all of the over-the-counter medications you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- Sit: Most of the day Half the day A little of the day
- Stand: Most of the day Half the day A little of the day

- Computer work:** Most of the day Half the day A little of the day
 On the phone: Most of the day Half of the day A little of the day

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today? _____

Patient Signature _____

Date: _____