



CONFIDENTIAL APPLICATION FOR TREATMENT

Patient's Name _____ Date of Birth _____

Please check the type of care desired:

___ Temporary Relief ___ Stabilization ___ Family Health/Prevention ___ Doctor's Advice

Address: _____

Street Apt. # Address City State Zip Code

Home Ph: _____ Work Ph: _____ Cell Ph: _____ E-Mail: _____

Sex: Male ___ Female ___ Age: _____ Marital Status: S M D W No. of Children _____

SS# _____

Patient's Occupation: _____ Patient's Employer: _____

Employer's Address: _____

Street Apt.# Address City State Zip Code

Name of Spouse/ Guardian: _____ Home Phone: _____

Spouse's Work Phone: _____ Spouse's Employer: _____

Employer's Address: _____

Emergency Contact: _____ Relationship: _____

Contact's Address: _____ Phone: _____

Street Address City State Zip

Who referred you to us? _____

Primary Care Physician: _____ Phone: _____

Insurance company: _____ Are you pregnant? Yes ___ No ___

Any chiropractor consulted in past? _____ Years seen: _____

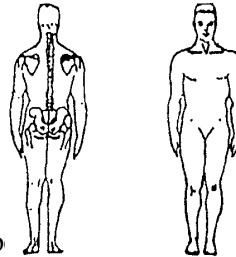
Are you seeking care due to an ___ Auto Injury ___ Illness ___ Injury on Job ___ Other

Original date of accident/ injury/onset of illness: _____

If no specific injury/accident, what is date of most recent flare-up: _____

Total number of similar episodes: _____

Please mark the exact location of your pain/symptoms on the figure(s). Describe your chief complaint(s)



Symptoms down ___ arm(s) or ___ leg(s) (check)

How did it start: (i.e. injuries/accident(s), postural stress (rep _____), other or unknown):

Had anything like this before? Yes /No If yes, explain: _____

Check either: ___ Gradually ___ Suddenly Check the frequency: ___ Intermittent ___ Frequent ___ Constant

Check the type of symptom: ___ Numbness ___ Tingling ___ Burning ___ Sharp ___ Dull ___ Achy ___ Sore

Other: _____

What makes your condition worse? Check: ___ Bending ___ Twisting ___ Lifting ___ Sitting ___ Standing

___ Sleeping ___ Changing positions ___ Other (explain) _____

What makes it better? _____

Is your condition: ___ Getting better ___ Getting worse ___ Staying the same?

Prior treatment for this condition? ___ Yes ___ No If yes, check all that apply: ___ prescribed medications

___ over-the-counter medications ___ ointments ___ massage ___ hot packs ___ cold packs ___ stretching/exercises

___ injections (shots) ___ physical therapy ___ surgery ___ chiropractic ___ other: _____



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Date of most recent Dr. visit: _____ X-Ray/MRI/CT: where _____ when _____

Does this condition cause you to be (check): moody irritable interrupts sleep restricted on daily activities

Does this affect your work? decision making poor attitude decreased productivity exhausted at end of day

Does this affect your life? Lose patience with loved ones restricted household duties hinders ability to exercise
 interferes with ability to participate in hobbies or other desired activities

Check the following if you have now or in the past:

- Weight Change Numbness Nervous Disorder Stress Difficulty C-Section
- Frequent Infections Cold Hands/Feet Digestive Problems Surgery Use Tobacco
- Respiratory Disease Asthma Cancer Diabetes Drink Coffee
- Sinus Problems High Cholesterol Menstrual Problems Arthritis Drink Alcohol
- Heart Disease Stroke HIV or AIDS Concussion Drink Diet Drinks
- Allergies Fatigue Jaw Trouble Head Injury
- Hardening of the arteries High/low blood pressure (circle which)
- Changes in bowel/bladder habits Headaches (No. days per wk. _____)

Other serious health conditions: _____

List details of family members with significant health problems: _____

Sleep position: Back Stomach Side Number of pillows under head _____

Sleep disturbance(s): Yes No Age of mattress: _____

Even if you "didn't get hurt," please list all past injuries/accidents (including childhood): falls/slips (on ice, steps, bikes etc.) motor vehicle accidents sports injuries

Dates/ Details: _____

List participation in all sports: _____

Work Duties/Daily Habits:

Y/N Do you sit more than 1 hour at a time? Y/N Do you perform a lot of desk/computer work?

Y/N Do you cradle phone shoulder to ear? Y/N Do you bend and twist a lot?

Y/N Do you lift more than 20 lbs. repetitively

Are you on a work release? Y/N (circle) If yes ordered by: _____ Until: _____

Drugs you now take (Including birth control & over the counter): _____

Are you familiar with all the possible side effects of your medications? Yes No

Exercise (what type, how many days per week)? _____

Do you eat 7 or more servings of fruits and vegetables a day? Yes No

Do you want information on nutrition and/or supplements? Yes No

Signature: _____ Date: _____

Copies : _____
