

PATIENT APPLICATION SURVEY

Last Name: _____ First: _____ M.I. _____ (Age) _____ Gender M F
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Marital Status: S M D W
Employer Name: _____ EMP. Phone: () _____ Occupation: _____
Spouse's Name: _____ Work Phone: () _____ Cell Phone: () _____
Responsible Party: Self Spouse Other: _____ Insured's Employer: _____
Emergency Contact: _____ Relationship: _____ Phone: () _____
How were you referred to this office? _____
Physician (Full Name) _____ Phone Number: () _____

HEALTH HISTORY & LIFESTYLE

CERVICAL SPINE (Neck):

1. Neck Pain
2. Pain into your Shoulders/Arms/Hands
3. Numbness/Tingling in Arms/Hands
4. Hearing Disturbances
5. Weakness in Grip
6. Headaches
7. Dizziness
8. Visual Disturbances
9. Coldness in Hands
10. Thyroid Conditions
11. Sinusitis
12. Allergies/Hay Fever
13. Recurrent Colds/Flu
14. Low Energy/Fatigue

TMJ/Pain/Clicking – Explain: _____

THORACIC SPINE (UPPER BACK):

1. Heart Palpitations
2. Heart Murmurs
3. Tachycardia
4. Heart Attacks/Angina
5. Recurrent Lung Infections/Bronchitis
6. Asthma/Wheezing
7. Shortness of Breath
8. Pain on Deep Inspiration/Expiration

THORACIC SPINE (MID BACK):

1. Mid back pain
2. Pain into your ribs/chest
3. Indigestion/Heartburn
4. Reflux
5. Nausea
6. Ulcers/Gastritis
7. Hypoglycemia
8. Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK)

1. Pain into your hips/legs/feet
2. Numbness/Tingling in your legs/feet
3. Coldness in your legs/feet
4. Muscle cramps in you legs/feet
5. Constipation/Diarrhea
6. Weakness/Injuries in your hips/knees/ankles
7. Recurrent bladder infections
8. Frequent/difficulty urinating
9. Menstrual irregularities/cramping (females)
10. Sexual dysfunction
11. Low back pain

Please list any health conditions not mentioned:

Please list any medications you are currently taking and their purpose:

Please list all past surgeries:

Please list all previous accidents and falls:

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilate's Swimming Other: _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____