ChiropracticUSA™

Patient Application For Treatment

Today's Date: _____ E-mail: _____ Gender: M F
Name: _____ Date of Birth: _____ Age: _____
Your Address: _____ City: _____
State: _____ Zip: _____ SS #: _____ Home #: _____
Name of Employer: _____ Work #: _____
Marital Status: S M W D Referred By: _____ Cell #: _____
How Many Children Do You Have? _____ What Are Their Ages? _____
Have You Or Any Other Members of Your Family Received Chiropractic Care? [ ] Yes [ ] No
How Long Has It Been? _____
Emergency Contact: _____ Phone #: _____
Who Is Responsible For Your Bill? [ ] Self [ ] Spouse [ ] Worker's Compensation [ ] Medicaid
[ ] Medicare [ ] Auto Insurance [ ] Personal Health Insurance [ ] Other: _____
Purpose Or Reason For Today's Appointment?_____
How Often Do You Drink Alcoholic Beverages? _____
Do You Smoke? [ ] Yes [ ]No How Much? _____
Do You Exercise? [ ] Yes [ ]No How Much? _____ Type? _____
Do You have Any Allergies? [ ] Yes [ ] No Specify: _____

Have you Ever Suffered From or Been Diagnosed As Having: (circle yes or no for each)

Y N *Broken or Fractured Bones
Y N Circulatory Problems
Y N Rheumatoid Arthritis
Y N Seizures/Convultions
Y N A Congenital Disease
Y N Excessive Bleeding
Y N High/Low Blood Pressure
Y N Diabetes
Y N Epilepsy
Y N Pacemaker
Y N Strokes
Y N *Cancer

Y N Ulcers
Y N Ruptures
Y N Coughing Blood
Y N Osteoarthritis
Y N Eating Disorder
Y N Alcoholism
Y N Drug Addition
Y N HIV Positive
Y N Gall Bladder
Y N *Head Problems
Y N Depression
Y N Tumors

Explain: _____

Medication List

Name of Medication	Name of Vitamins	Date Started	Date Stopped

Healthcare Provider Team

Other providers seen for the same condition:_____

Who is currently your
Chiropractor:_____
Primary Care Physician:_____
Physical Therapist: _____
Dentist: _____

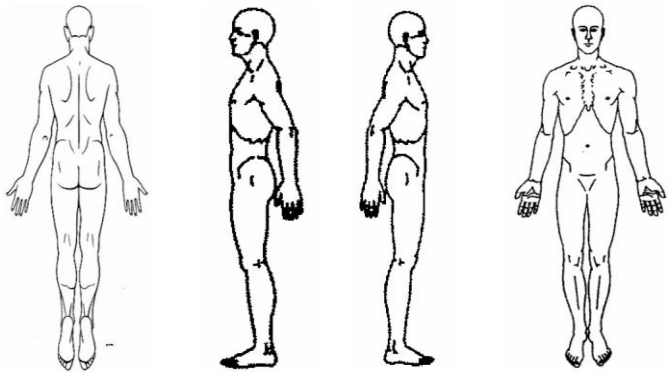
Massage Therapist: _____
Personal Trainer: _____
Acupuncturist: _____
Health Club: _____
Other:_____

Date:_____ Patient Name:_____ Account #:_____

PATIENT HISTORY

Using the letters below, please show where you are experiencing all of your complaints on the diagram:

A. Ache
B. Burning
C. Cramping
D. Dull Pain
F. Stiffness
N. Numbness
R. Throbbing
S. Soreness
T. Tingling
X. Sharp Pain



	1st Complaint	2nd Complaint	3rd Complaint	4th Complaint	5th Complaint
Complaint:					
When did it start?					
On a scale of 1 -10	Current:	Current:	Current:	Current:	Current:
1 = mild	Average:	Average:	Average:	Average:	Average:
5 = moderate	At Best:	At Best:	At Best:	At Best:	At Best:
10 = severe	At Worst:	At Worst:	At Worst:	At Worst:	At Worst:
Rate your pain levels:					
What % of the time does it occur?	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100	10 20 30 40 50 60 70 80 90 100
When does it occur most?	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____	__AM __PM __Night _____
How long does it last?	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant	__Minutes __Hours __Days __Constant
What makes it better?					
What makes it worse?					

Do you currently have pain and/or difficulty performing any of the following activities? (Circle Y or N)

Walking	Y N	Kneeling	Y N	Grooming	Y N	Driving	Y N
Bending	Y N	Sitting	Y N	Standing	Y N	Exercising	Y N
Sleeping	Y N	Lifting	Y N	Running	Y N	Housework	Y N

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1. Have you ever had the condition(s) in the past? [ ] Yes [ ] No
   If yes, please indicate if any treatment was received and what type of treatment:
   [ ] Hospitalization [ ] Chiropractic care [ ]Medical doctor / specialty provider [ ] None
2. Have you ever lost time from work due to your condition(s)? [ ] Yes [ ] No
   If Yes, dates? _____
3. Are you pregnant? [ ] Yes [ ] No
4. What was the first day of your last menstrual cycle? _____
5. Number of pregnancies? _____ Number of miscarriages? _____

Patient Signature: _____ Date: _____

Doctors Signature: _____Date:_____

Systems Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Do not leave any blanks.

_____ High Blood Pressure
_____ Dizziness / Fainting
_____ Insomnia
_____ Low Resistance
_____ Tension
_____ Confusion
_____ Fatigue
_____ Ulcers
_____ Eye/Vision Problems
_____ Ear/Hearing Problems
_____ Difficulty Breathing
_____ Heart Problems
_____ Loss of Bladder Control
_____ Constipation
_____ Diarrhea
_____ Digestion Problems
_____ Nausea
_____ Female Problems
_____ Prostate Problems
_____ Diabetes
_____ Hands / Feet Cold
_____ Loss of Memory
_____ Nervousness
_____ Sweaty Palms
_____ Speech Difficulty
_____ Anxiety
_____ Depression
_____ Irritability

Anyone in your family have or had:

___ stroke ___ arthritis
___ cancer ___ hypertension
___ heart problems ___ diabetes

Please circle if you have any of the following:

_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____ Skin	Rashes, eruptions, changes in wart or moles, pigmentation changes, bruises, itching, hair loss, nail changes
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Changes in acuity photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____ Nose	Rhinorrhea, Epistaxis, allergies, airway obstruction
_____ Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____ Neck	Stiffness, lumps / swelling / masses, pain
_____ Lungs	Cough (productive / nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____ Cardiac	Palpations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____ Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____ Gastrointestinal	Unusual diet, sysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes,hematures, sexually transmitted diseases, dyspareunia, scrotal swelling
_____ Genitournary	Polyuria nocturia, oliguria, dysuria, uregency, incontinence, urine color change
_____ Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstruation, history, pregnancy history,dysmenorrheal, premenstrual syndrome, climacteric
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement,/pain
_____ Musculoskelatal	Bone/joint pain, swelling, joint deformity, trama, restricted ROM, weakness, atrophy
_____ Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, parasthesia
_____ Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s).

Problems List

Dr. Name/Facility Problem TXT received When to When

1._____
2._____
3._____
4. _____