Application for Chiropractic Treatment

Name: ______________________ Date: ___/___/___
Address: ______________________
City: ______________________ State: ______ Zip: ______
Tel: Home: ( ) - Mobile: ( ) - Work: ( ) -
*Please circle the best number to reach you: HOME / MOBILE / WORK
Sex: Male / Female Date of Birth: ___/___/___
Employer: ______________________ Occupation: ______________________
Marital Status: M / S / D / W Spouse's Name: ______________________
Spouse's Employer: ______________________ Spouse's Work #: ( ) -
Person responsible for this account: ______________________
Person to notify in case of emergency: ______________________ Tel: ( ) -
Relation: ______________________
Who Referred you to us? ______________________

INSURANCE INFORMATION

Primary Insurance

Name of Insured: ______________________ INS ID # ______________________
Name of Insurance Company: ______________________
Insured's Employer ______________________ Group Policy #: ______________________
Insurance Company: ______________________
Address: ______________________
City: ______________________ State: ______ Zip: ______
Telephone: ( ) - Fax: ( ) -

Secondary Insurance

Name of Insured: ______________________ SS# ___-___-___
Name of Insurance Company: ______________________
Insured's Employer ______________________ Group Policy #: ______________________
Insurance Company: ______________________
Address: ______________________
City: ______________________ State: ______ Zip: ______
Telephone: ( ) - Fax: ( ) -

I understand that I am responsible for all fees incurred for myself or a dependent, regardless of insurance benefits available, and that insurance benefits are estimated and billed as a courtesy. Billing my insurance does not guarantee they will pay on my account, and does not release me from payment for unpaid services.

______________________ ___/___/___
Signature of Patient or Parent/Guardian of Minor/Dependent Date

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Patient Name: ______________________ **Date:** ____/____/____

What condition or injury are you seeking care for? ______________________

Date of injury or date symptoms began: ____/____/____

Is this injury due to a motor vehicle accident? YES / NO

At the time of injury, were you working? YES / NO If yes, have you notified your employer? YES / NO

If you answered YES to any of the preceding questions, please answer the following:

Do you have an attorney? YES / NO

Attorney Name: ______________________ Tel: ( ) -

Have you seen any other Doctors for this injury? YES / NO

Doctor's Name: ______________________ Tel: ( ) -

Address/Location Seen: ______________________

What was the diagnosis? ______________________

Were x-rays taken? YES / NO

What treatment was administered? ______________________

What medications were you given? ______________________

Pre-Existing Conditions

Have you sought care for a health condition in the past: 1 year? YES / NO 2 years? YES / NO

If YES, what condition? ______________________

What treatment was administered? ______________________

Do you take medication for any condition? YES / NO

Please list the medication name, dosage, reason for taking, and how long you have been on each medication.

Do you smoke? Yes / No How much? _______ Do you drink alcohol? Yes/ No How much? _______

Please list all allergies you may have: ______________________

Past surgeries (please list the date and reason for each): ______________________

Past injuries/accidents (please list the date and a detailed account of each): ______________________

Family History: (please list any family history of major illness, diabetes, heart, lung, etc)

CHIROPRACTIC SYMPTOM SURVEY

Please check any symptoms you experience.

Symptom	Always	Sometimes	Never
1. Slight stiffness	❑	❑	❑
2. Headaches	❑	❑	❑
3. Sinus trouble	❑	❑	❑
4. Tightness in shoulders	❑	❑	❑
5. Some numbness in fingers	❑	❑	❑
6. Pain in shoulders, perhaps thought to be bursitis	❑	❑	❑
7. Mild visual disturbances	❑	❑	❑
8. Occasional twinges of pain that seem to go away	❑	❑	❑
9. Tightness in the lower back	❑	❑	❑
10. Some numbness or tingling into feet or toes	❑	❑	❑
11. Cramping in the legs, maybe thought to be growing pains	❑	❑	❑
12. Occasional gas, bloating, heartburn, or digestive difficulties	❑	❑	❑
13. Severe menstrual pain	❑	❑	❑
14. Abdominal cramps	❑	❑	❑
15. Fatigue when standing	❑	❑	❑
16. Pain that goes away with exercise	❑	❑	❑
17. Increasing stiffness, usually worse in the morning	❑	❑	❑
18. Numbness and tingling into the arms and/or hands	❑	❑	❑
19. Pain across the shoulders; may spread into arms	❑	❑	❑
20. Dizziness	❑	❑	❑
21. Muscular weakness	❑	❑	❑
22. Loss of coordination	❑	❑	❑
23. Clumsiness	❑	❑	❑
24. Chest Pain	❑	❑	❑
25. Easily irritated	❑	❑	❑
26. Low back pain that radiates to the legs	❑	❑	❑
27. Groin pain with occasional constipation	❑	❑	❑
28. Diarrhea	❑	❑	❑
29. Chronic bowel problems	❑	❑	❑
30. The "back that always goes out" syndrome	❑	❑	❑
31. Pain that is NOT alleviated by exercise; may be made worse	❑	❑	❑
32. Need for over the counter pain medication	❑	❑	❑
33. Severe pain sometimes; sometimes none at all	❑	❑	❑
34. Greatly reduced movement	❑	❑	❑
35. General overall stiffness	❑	❑	❑
36. Atrophy or wasting of shoulder and arm muscles	❑	❑	❑
37. Weakness of grip strength	❑	❑	❑
38. Chronic fatigue	❑	❑	❑
39. Insomnia	❑	❑	❑
40. Numbness or pain in the facial area	❑	❑	❑
41. Frequent upper respiratory infections and colds	❑	❑	❑
42. Weight gain	❑	❑	❑
43. Chronic sinus trouble	❑	❑	❑
44. Sharp pain into the arms or hands	❑	❑	❑
45. Constant episodes of lower back pain for no apparent reason	❑	❑	❑

46. Exercise makes your pain worse	❑	❑	❑
Symptom	**Always**	**Sometimes**	**Never**
47. Low back pain that comes and goes	❑	❑	❑
48. Leg weakness	❑	❑	❑
49. Difficulty walking upstairs	❑	❑	❑
50. Pain and swelling in the feet	❑	❑	❑
51. Increasing pelvic problems	❑	❑	❑
52. Loss of coordination when walking	❑	❑	❑
53. Difficulties or pain with urination	❑	❑	❑
54. Varicose veins	❑	❑	❑
55. Need for prescription pain relievers	❑	❑	❑
56. Need prescription medication for organ dysfunction	❑	❑	❑
57. Diabetes, adult onset	❑	❑	❑
58. Diabetes, since childhood	❑	❑	❑
59. Prostate issues	❑	❑	❑
60. Hysterectomy	❑	❑	❑
61. Depression or anxiety attacks	❑	❑	❑
62. Prescription medication for depression or anxiety	❑	❑	❑
63. Loss of range of motion or flexibility	❑	❑	❑
64. Chronic, unrelenting pain	❑	❑	❑
65. Unexplained weight loss	❑	❑	❑
66. Difficulty losing weight	❑	❑	❑
67. Dependant upon prescription medications for health reasons	❑	❑	❑
68. High blood pressure	❑	❑	❑
69. Heart problems	❑	❑	❑
70. Unable to exercise due to pain	❑	❑	❑
71. Too tired to eat	❑	❑	❑
72. Gall bladder attacks	❑	❑	❑
73. Gall bladder removed	❑	❑	❑
74. Difficult to walk by yourself; may need assistance	❑	❑	❑
75. Wasting or atrophy of leg muscles	❑	❑	❑
76. Poor circulation	❑	❑	❑
77. Severe bowel & digestive problems	❑	❑	❑
78. Severe female trouble	❑	❑	❑
79. Severe bladder & urinary trouble	❑	❑	❑
80. Rapid or uneven heartbeat	❑	❑	❑
81. Acid or sour stomach	❑	❑	❑
82. Immune troubles	❑	❑	❑
83. Difficulty breathing easily	❑	❑	❑
84. Difficulty getting to sleep	❑	❑	❑
85. Difficulty sleeping through the night; wake up at times	❑	❑	❑

Please alert us as to any other health concerns in the lines below:

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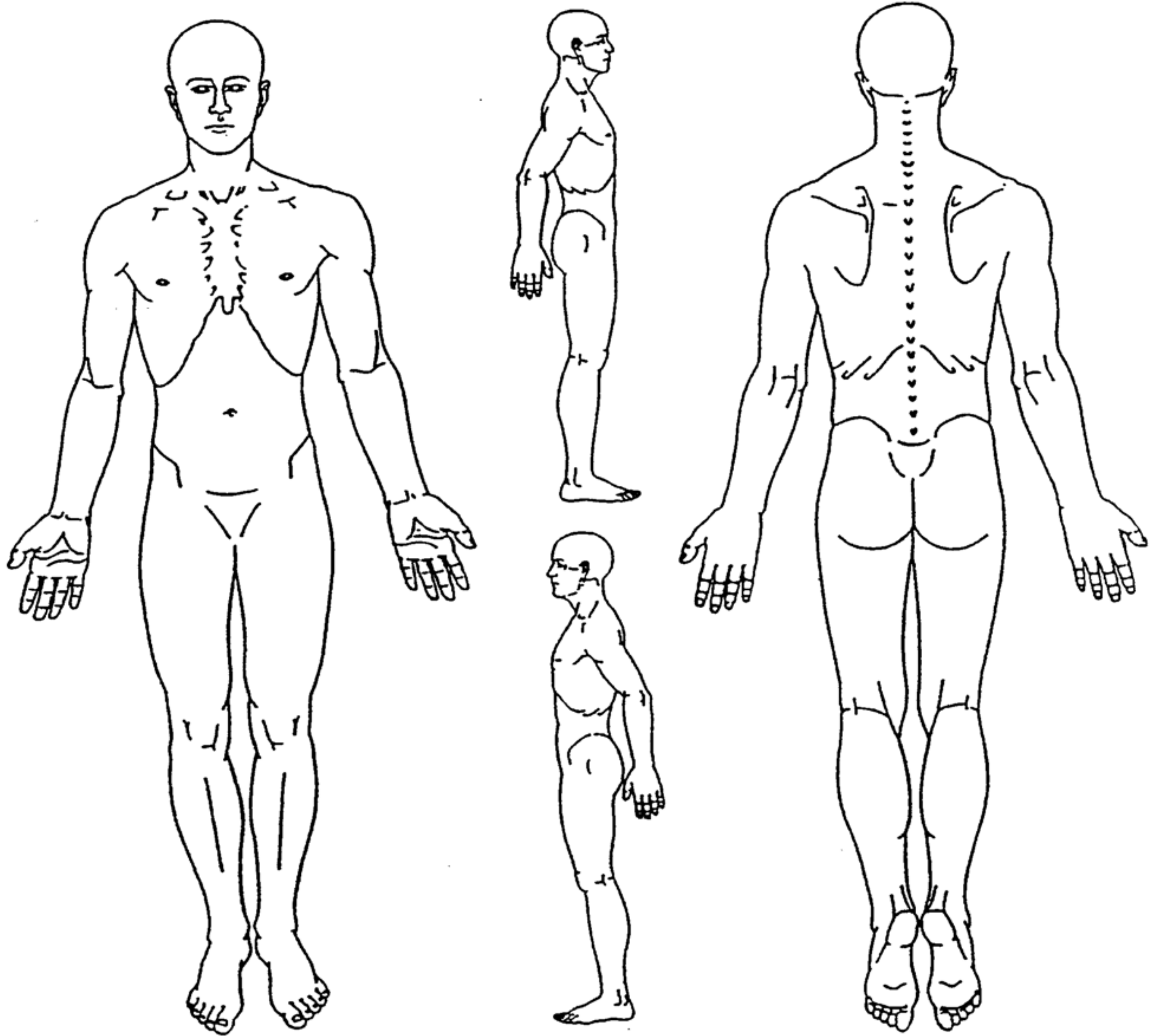
PAIN DRAWING

NAME: ______________________________ DATE: ______________

Please be sure to fill out the form being as descriptive as possible. Mark the area(s) on your body (front & back, face and head) where you feel the sensations listed below. Draw areas of radiating pain (pain that travels). IF NEEDED, WRITE NOTES ALONGSIDE THE PICTURES.

NUMBNESS	PINS & NEEDLES	BURNING PAIN	STABBING PAIN	ACHING PAIN
_ _ _ _ _ _ _ _ _ _ _ _ _ _ _	OOOOOOOOOOOOO	XXXXXXXXXXXXX	//////////////////////////	((((((((((((((((((((



VISUAL ANALOGUE SCALE

MAKE ONE (1) VERTICAL MARK (|) along the line below that you feel represents your current level of pain in the major area of injury. Make your line between the areas of "no pain at all" and "worst pain experienced."

NO PAIN AT ALL ______________________________ WORST PAIN EXPERIENCED