



## Patient Application for Treatment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Male / Female

Home #: \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Information: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ Spouse's DOB: \_\_\_\_\_

How Many Children Do You Have? \_\_\_\_\_ Children's Ages: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How Often Do You Drink Alcoholic Beverages? \_\_\_\_\_

Do You Smoke?  Yes  No How Much? \_\_\_\_\_

Do You Exercise?  Yes  No How Often? \_\_\_\_\_

Do You Have Any Allergies? (specify) \_\_\_\_\_

Are You Pregnant? \_\_\_\_\_ Date of Last Menstrual Period? \_\_\_\_\_

Have You Ever Received Chiropractic Care? Yes No X-Rays Taken? Yes No

When Was Your Last Adjustment? \_\_\_\_\_ Which Office? \_\_\_\_\_

Who May We Thank For Referring You To The Office? \_\_\_\_\_

What Medications Are You Currently Taking? \_\_\_\_\_

What Surgeries Have You Had? \_\_\_\_\_

List Any Recent Accidents or Falls: \_\_\_\_\_

## Chief Complaint

What Is Your Primary Complaint? (Why are you here today): \_\_\_\_\_

How Long Have You Been Experiencing This Problem? \_\_\_\_\_

On A Scale of 1 to 10, How Severe Is It At It's Worst From 0 (no pain) to 10 (disabling pain)

0      1      2      3      4      5      6      7      8      9      10

What Percent of Your Awake Time Do You Experience Your Main Complaint? (Circle)

0      10      20      30      40      50      60      70      80      90      100%

What Makes It Feel Better? \_\_\_\_\_

What Makes It Feel Worse? \_\_\_\_\_

When Do You Notice It Most? (circle) Morning    Afternoon    Evening

I Have:  Been Hospitalized     Been Seen By Another Chiropractor

Been Seen By Another Doctor     Never Received Treatment For This Problem.

On the diagram below, label ALL areas you are experiencing symptoms using the appropriate letter from the box below.

**A=Aching C=Cramping R=Throbbing Pain N=Numbness O=Other**  
**B=Burning D=Dull Pain S=Stiffness T=Tingling**

## Additional Complaints

Mark with an "X" Current Symptoms and "O" Past Symptoms

- |                               |                             |                           |
|-------------------------------|-----------------------------|---------------------------|
| _____ Arthritis               | _____ Shoulder Pain         | _____ PMS                 |
| _____ Diabetes                | _____ Ear Infections        | _____ Menopausal Problems |
| _____ Swollen/ Painful Joints | _____ Low Back Pain         | _____ Foot Trouble        |
| _____ Cancer                  | _____ Pain w/ Cough/Sneeze  | _____ Fainting            |
| _____ Depressed               | _____ Chest Pain            | _____ Coughing Blood      |
| _____ Allergies/ Sinus        | _____ Hip Pain              | _____ Pacemaker           |
| _____ Trouble Sleeping        | _____ Gall Bladder          | _____ HIV Positive        |
| _____ Headaches               | _____ Stroke                | _____ Tumors              |
| _____ Trouble Concentrating   | _____ Ulcers                | _____ Eating Disorder     |
| _____ Learning Disability     | _____ High/ Low BP          | _____ Epilepsy            |
| _____ Mood Changes            | _____ Heartburn             | _____ Congenital Disease  |
| _____ Dizziness               | _____ Heart Problems        | _____ Alcoholism          |
| _____ Neck Pain               | _____ Kidney Problems       | _____ Drug Addiction      |
| _____ Numbness/ Tingling      | _____ Bed Wetting           | _____ Excessive Bleeding  |
| _____ Hands/Legs/Feet         |                             |                           |
| _____ Shoulders Feel Tired    | _____ Diarrhea/Constipation | _____ Heart Attack        |
| _____ TMJ Pain                | _____ Tremors               | _____ Migraines           |
| _____ Asthma                  | _____ Colon Trouble         | _____ Broken Bones        |
|                               |                             | List: _____               |
| _____ Loss of Balance         | _____ Prostate Problems     | _____ ADD/ ADHD           |
| _____ Upper/ Mid Back Pain    | _____ Menstrual Problems    | _____ Thyroid Problems    |



**Previous Chiropractic and Physical Therapy Care:**

Have you ever seen a Chiropractor before?    Yes    No  
 How many Visits?    1 x week    2 x week    3 x week    daily  
 How many weeks?    1 week    3 weeks    8 weeks    9+weeks  
 Do you think Chiropractic can help you? Yes    No    How long do you think it will take? \_\_\_\_\_

**Previous Massage Care:**

Have you ever had a therapeutic massage before?    Yes    No  
 How often?    1 x week    1 x month    1 every 3 months    1 per year  
 Do you think massage can help you?    Yes    No    How long do you think it will take? \_\_\_\_\_

*I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation and I am responsible for payment of healthcare services.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Health History of Family Members**

The reason for this form is to assist the doctor by providing past health history information for their review

Condition	Self	Mother	Spouse	Brothers	Sisters	Children
Arthritis						
Asthma						
Back Pain						
Cancer						
Constipation						
Diabetes						
Difficulty Sleeping						
Disc Problems						
Ear Problems						
Emphysema						
Epilepsy/ Seizures						
Fatigue						
Headaches						
Heart Problems						
High Blood Pressure						
Kidney Trouble						
Migraine						
Nervousness						
Neck Pain						
Numbness						
Pinched Nerve						
Scoliosis						
Sinuses & Allergies						
Stomach Trouble						