Patient Application

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is *very unique and different*, highly specialized and advanced even compared to other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if *you are a case we can accept*. Please feel free to ask any questions if you need any assistance. ***We look forward to serving you.***

ABOUT YOU

Name: _____ Date: __/__/__ Sex: M / F Birth Date: __/__/__ Age: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Spouse's Name _____ Do you have children? ❑Yes ❑No How many? _____

Email: _____ Employer: _____ How long? _____

Occupation: _____ How did you hear about our office **(Please be specific)**? ❑Twitter ❑Website ❑Facebook ❑Sign ❑Doctor OutReach Presenation ❑Answers Employee ❑Patient: _____ ❑Other: _____

IN EVENT OF EMERGENCY

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: (___) _____ Other Phone: (___) _____

Who is your Medical Doctor? _____ Phone: (___) _____

May we send an initial/final report to your other doctors of what we find during your visit? ❑ Yes ❑ No

INSURANCE INFORMATION

The front desk staff will ***need*** a copy of your ***driver's license*** and/or ***insurance cards.***

HEALTH HISTORY

- Please list anything you may be **allergic to:** _____
- List previous **surgeries** with dates: _____
- List any **past serious accidents** with dates: _____
- Family Health History: _____

Do you: Take Supplements or Vitamins? ❑Yes ❑No Exercise? ❑Yes ❑No Are you on a special diet? ❑Yes ❑No Since: __/__/__
Do you smoke? ❑Yes ❑No How much? _____ How long? ___ Are you wearing: ❑Heel lifts ❑Sole lifts ❑Inner soles ❑Arch supports
What age is your mattress? _____ Is it comfortable? ❑Yes ❑No Do you have a support pillow? ❑Yes ❑No How long? _____
******For women:*** Are you taking Birth Control? ❑Yes ❑No Are you pregnant? ❑Yes ❑No How long? ___ Nursing? ❑Yes ❑No

REASON FOR YOUR VISIT

List your main-top concerns: (please explain)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you EVER had any of the following diseases or conditions?

CERVICAL SPINE (Neck): *Postural distortions from **low nerve flow** (causing **Forward Head Syndrome**) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?*

- ❑ Neck pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Weakness in grip
- ❑ Hearing disturbances
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent Colds/Flu's
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (Upper back): *Postural distortions from **low nerve flow** (resulting from **Forward Head Syndrome**) in the upper back will weaken the nerves into your heart and lungs affecting these parts of your body. Do you experience…?*

- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia (heart beating rapidly)
- ❑ Heart attacks/Angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

THORACIC SPINE (Mid back): *Postural distortions from **low nerve flow** (resulting from **Forward Head Syndrome**) in your mid back will weaken the nerves into your chest/ribs and upper digestive tract affecting these parts of your body. Do you experience…?*

- ❑ Mid back pain
- ❑ Pain into your ribs/chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia (altered blood sugar)
- ❑ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (Low back): *Postural distortions from **low nerve flow** (resulting from **Forward Head Syndrome**) in the low back will weaken the nerves into your legs/feet and pelvic organs affecting these parts of your body. Do you experience…?*

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Menstrual irregularities/cramping(females)
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in your legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Low Back Pain
- ❑ Sexual Dysfunction
- ❑ Constipation/Diarrhea

Please list any other serious medical conditions not mentioned:

TREATMENT HISTORY

Fill in other doctor(s) seen prior to your first visit to this office for your current condition.

Dr. _____ **How did you get there?** ❑Self ❑Somebody else ❑Ambulance ❑Police
First visit date:___/___/___ Treatment Type:_____ Last visit date:___/___/___
How many treatments received?_____ Currently treating? **❑Yes ❑No** Did treatments benefit you? **❑Yes ❑No**
X-rays done? **❑Yes ❑No** Body parts X-rayed?_____
Lab work done? **❑Yes ❑No** What lab work?_____

LIST your medications AND supplements/vitamins AND reason why (over the counter or PRESCRIBED)?

1._____ 4._____
2._____ 5._____
3._____ 6._____

SYMPTOM HISTORY

Prior Similar Symptoms

❑I have NOT had prior symptoms similar to my current complaints.

❑ I have had prior symptoms similar to my current complaints.

If so, occurred when _____❑months ago ❑years ago

OR on Date:___/___/_____

Has your LIFESTYLE Contributed to your Current Symptoms?

❑No ❑Not sure ❑Yes (list your lifestyle contributors):

1._____
2._____
3._____

❑My current complaints ❑ ARE NOT ❑ ARE worsened by:_____

_____

CURRENT SYMPTOMS

Describe your symptoms below, in the order of severity. Describe only *ONE* symptom *PER SECTION*.

First Symptom

1. Check only one body location below

ONSET:_____

❑Headaches	L❑	R❑	B❑
❑Front ❑Top ❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:_____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

How bad is it?

GOOD 0 1 2 3 4 5 6 7 8 9 10 BAD

Second Symptom

1. Check only one body location below

ONSET:_____

❑Headaches	L❑	R❑	B❑
❑Front ❑Top ❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:_____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

How bad is it?

GOOD 0 1 2 3 4 5 6 7 8 9 10 BAD

Third Symptom

1. Check only one body location below

ONSET:_____

❑Headaches	L❑	R❑	B❑
❑Front ❑Top ❑Back of Head			
❑Jaw	L❑	R❑	B❑
❑Eye	L❑	R❑	B❑
❑Neck	L❑	R❑	B❑
❑Upper Back	L❑	R❑	B❑
❑Mid Back	L❑	R❑	B❑
❑Low Back	L❑	R❑	B❑
❑Chest	L❑	R❑	B❑
❑Abdomen	L❑	R❑	B❑
❑Ribs	L❑	R❑	B❑
❑Buttocks	L❑	R❑	B❑
❑Shoulder	L❑	R❑	B❑
❑Upper Arm	L❑	R❑	B❑
❑Forearm	L❑	R❑	B❑
❑Hand	L❑	R❑	B❑
❑Hip	L❑	R❑	B❑
❑Leg	L❑	R❑	B❑
❑Foot	L❑	R❑	B❑

Other locations:_____

2. Types of pain

❑Dull ❑Sharp ❑Aching ❑Cutting
❑Throbbing ❑Burning ❑Numbing ❑Tingling ❑Cramping
❑Spasm ❑Stinging ❑Shooting ❑Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑Most all the time

4. Pain Intensity (How it affects daily activites)

❑Doesn't affect ❑Somewhat affects
❑Seriously affects ❑Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑Head	❑	❑	❑
❑Neck	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Arm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations of radiation:

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑In the A.M.	❑	❑	❑
❑In the P.M.	❑	❑	❑
❑Bending forwrd.	❑	❑	❑
❑Bending back	❑	❑	❑
❑Bending left	❑	❑	❑
❑Bending right	❑	❑	❑
❑Twisting left	❑	❑	❑
❑Twisting right	❑	❑	❑
❑Coughing	❑	❑	❑
❑Sneezing	❑	❑	❑
❑Straining	❑	❑	❑
❑Standing	❑	❑	❑
❑Sitting	❑	❑	❑
❑Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

How bad is it?

GOOD 0 1 2 3 4 5 6 7 8 9 10 BAD

ACTIVITIES OF DAILY LIVING ASSESSMENT

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

Please mark AFFECTED areas only.

1 = "I can do it ***without any difficulty***"
2 = "I can do it ***without much difficulty***, despite some pain"
3 = "I manage to ***do it by myself***, despite marked pain"
4 = "I manage to do it, despite the pain, but ***only if I have help***"
5 = "***I cannot do it*** all, because of the pain"

Difficulties with Self Care and Personal Hygiene Activities

____Bathing ____Drying hair ____Brushing teeth ____Putting on shoes ____Preparing meals ____Taking out trash
____Showering ____Combing hair ____Making bed ____Tying shoes ____Washing hair ____Doing laundry
____Eating ____Washing face ____Putting on shirt ____Putting on pants ____Cleaning dishes ____Going to the toilet

Difficulties with Physical Activities

____Standing ____Walking ____Kneeling ____Bending back ____Twisting left ____Leaning back
____Sitting ____Stooping ____Reaching ____Bending left ____Twisting right ____Leaning left
____Reclining ____Squatting ____Bending forward ____Bending right ____Leaning forward ____Leaning right
____Standing for long periods ____Sitting for long periods ____Walking for long periods ____Kneeling for long periods

Difficulties with Functional Activities

____Carrying small objects ____Lifting weights off floor ____Pushing things while seated ____Exercising upper body
____Carrying large objects ____Lifting weights off table ____Pushing things while standing ____Exercising lower body
____Carrying brief case ____Climbing stairs ____Pulling things while seated ____Exercising arms
____Carrying large purse ____Climbing inclines ____Pulling things while standing ____Exercising legs

Difficulties with Social and Recreational Activities

____Bowling ____Jogging ____Swimming ____Ice Skating ____Competitive Sports ____Dating
____Golfing ____Dancing ____Skiing ____Roller Skating ____Hobbies ____Dining Out

Difficulties with Traveling

____Driving a motor vehicle ____Riding as a passenger in a motor vehicle ____Riding as a passenger on a train
____Driving for long periods of time ____Riding as a passenger on an airplane ____Riding as a passenger for long periods

Please mark AFFECTED areas only.

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is ***not affected*** by my condition"
2 = "This area is ***slightly affected*** by my condition"
3 = "My condition ***moderately restricts*** my ability in this area"
4 = "My condition ***seriously limits*** my ability in this area"
5 = "My condition ***prevents*** me from using this ability"

Difficulties with Different Forms of Communication

____Concentrating ____Hearing ____Listening ____Speaking ____Reading ____Writing ____Using a keyboard

Difficulties with the Senses

____Seeing ____Hearing ____Sense of touch ____Sense of taste ____Sense of smell

Difficulties with Hand Functions

____Grasping ____Holding ____Pinching ____Percussive movement's ____Sensory discrimination

Difficulties with Sleep and Sexual Function

____Being able to have normal, restful nights sleep ____Being able to participate in desired sexual activity

ACCOUNT INFORMATION

- Please discuss any questions regarding our services as the best services are based on a friendly, mutual understanding between us.
- ***I authorize the staff to perform any necessary services needed during diagnosis and treatment.*** I also authorize the provider and or managed care organization to release any information required to process insurance claims.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- ***I understand the above information and guarantee this form was completed correctly*** to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/____

❑Adult Patient ❑Parent ❑Guardian ❑Spouse