TREATMENT APPLICATION

This treatment application is the first step in assisting the doctor in determining if you are a candidate for our non-surgical procedures, therapies and specialized treatment technology. Please answer the following questions honestly and to the best of your knowledge.

CONFIDENTIAL PATIENT INFORMATION

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date_____/_____/_____ S/S#_____-_____-_____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone _____Cell Phone_____Work Number _____

Sex: ❒ Female ❒ Male Birth Date_____/_____/_____ Email _____

Status: ❒ Minor ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated

Occupation_____ Please Explain Duties of Your Work_____

Spouse/ Partner Name _____ Phone_____

Person to contact in case of an emergency_____ Phone_____

How were you referred to our office?_____

Who is your Primary Care Physician?_____ Phone _____

HEALTH HISTORY

What type of regular exercise do you perform? (circle) None Light Moderate Strenuous Height:____ft. ____in. Weight:_____lbs.

Do you currently have or have you previously had any of the following symptoms or conditions**:**

Past	Present		Past	Present		Past	Present	
❒	❒	Headaches	❒	❒	Tension	❒	❒	Ringing/ Buzzing in Ears
❒	❒	Neck Pain	❒	❒	Irritability and Stress	❒	❒	Loss of Memory
❒	❒	Neck Stiffness	❒	❒	Mood Swings	❒	❒	Loss of Smell
❒	❒	Mid Back Pain	❒	❒	Sleeping Problems	❒	❒	Loss of Taste
❒	❒	Low Back Pain	❒	❒	Fatigue	❒	❒	Upset Stomach
❒	❒	Pain In Arm and/or Legs	❒	❒	Depression	❒	❒	Constipation
❒	❒	Burning on the Feet	❒	❒	Chest Pain	❒	❒	Diarrhea
❒	❒	Pins and Needles in Arms	❒	❒	Shortness of Breath	❒	❒	Urinary Problems
❒	❒	Pins and Needles in Legs	❒	❒	Cold Sweats	❒	❒	Heartburn
❒	❒	Numbness in Fingers	❒	❒	Fever	❒	❒	Ulcers
❒	❒	Numbness in Toes	❒	❒	Fainting	❒	❒	Easy bleeding/ bruising
❒	❒	Cold Hands and/or Feet	❒	❒	Dizziness	❒	❒	Menstrual Pain
❒	❒	Skin Sensitivity To Touch	❒	❒	Loss of Balance	❒	❒	Menstrual Irregularity
❒	❒	Nervousness	❒	❒	Light Sensitivity w/Eyes	❒	❒	Hot flashes
❒	❒	Skin Disorders	❒	❒	Loss of Vision	❒	❒	Intimacy/Sex-related
❒	❒	∗Urine flow / bowel difficulties	❒	❒	Chronic use of steroids	❒	❒	∗Cancer:_____
❒	❒	Hip Surgery/Injury	❒	❒	Recent Spine Fracture	❒	❒	Osteoporosis / Causing Fractures

Other Disorders:

Have **YOU** or **A FAMILY MEMBER** ever been diagnosed with any of the following conditions**:**

❍ ❒ AIDS/HIV/Hepatitis C	❍ ❒ Heart Disease	❍ ❒ Thyroid Disorders
❍ ❒ Cancer (in family)	❍ ❒ Diabetes	❍ ❒ Respiratory/COPD
❍ ❒ High Blood Pressure	❍ ❒ Stroke	❍ ❒ Other Medical

Conditions Not Listed: _____

Have you had MRI's/CT's taken? __ No __ Yes. Of **what part** of your body ____ When _____
Where (what facility took them)_____Did you bring your MRI report? _____

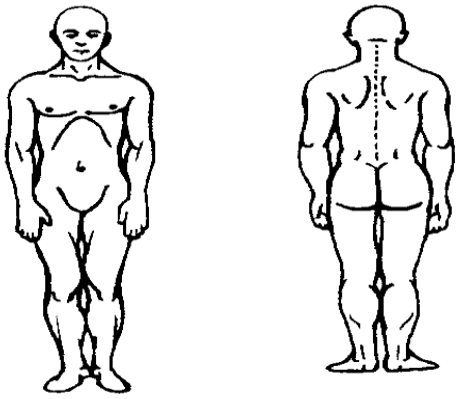
PLEASE LIST YOUR CURRENT PROBLEMS OR COMPLAINTS: (Chief complaint or present illness)

1) _____ 2) _____ 3) _____ 4) _____

What % of the day do these symptoms bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= ^^^^^
Shooting	= →
Other_____	= ***



Please circle the appropriate number(s) for the intensity of your pain and the appropriate letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time)
F = Frequent (51-75%)

I = Intermittent (26-50%)
C = Constant (76-100%)

Area of Pain / Symptom & Intensity	**Normal**	**Minimal**	**Slight**			**Moderate**			**Severe**				**Frequency**			
													25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Hips L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Shoulders L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Arms L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Hands L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Legs L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Feet L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C

Is your pain due to a motor vehicle accident (MVA) or work injury? Yes ☐ No ☐

If yes, did you have neck, upper back or back pain immediately (within 12 hours)? Yes ☐ No ☐

If yes, did you have any initial decreased neck range of motion? Yes ☐ No ☐

If yes, did you have numbness, tingling or weakness initially? Yes ☐ No ☐

If yes, did you experience headaches, sleep disturbance or fatigue initially? Yes ☐ No ☐

If yes, did you have any neurological symptoms; radiating pain into upper extremities? Yes ☐ No ☐

If yes, did you have any radiating pain into upper extremities? Yes ☐ No ☐

Is it worse in the morning or as the day progresses? _____

Does anything relieve your pain?_____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? ❒Sitting ❒Standing ❒Walking ❒Bending – Direction? _____ ❒Lying Down

❒Other _____

Describe on the scale how the pain has affected your work & activity (both inside and outside the home, and housework)

0 none 1 2 3 4 5 moderate 6 7 8 9 10 extremely

In General, how would you rate your overall health right now? Excellent Very Good Good Fair Poor

Please describe any other activities/hobbies that are restricted due to these symptoms?_____

_____

When did you first notice these symptoms?_____ Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When?_____

Have you had an injury or fall? ❒ No ❒ Yes, Describe_____

Have you been **diagnosed with herniated / bulging disc/ or another spine condition**? ___ Yes ___ No
Describe: _____

_____

Have you had Lab tests or Xray's for this condition? ❒ No ❒ Yes Where? _____ When? _____

What kinds of treatments have you received for the above condition **(your chief complaint)?**

Epidural: How Many _____ When(approx) _____
Physical Therapy: How Long _____ When _____
Surgery: Type_____ When _____
Type_____ When _____
Other Care: _____ When _____
_____ When _____

Did any of these treatments work? If so, which one(s)? For how long?

_____

_____

Any other surgeries: Type_____ When _____
Type_____ When _____

Past Chiropractic Care: Yes / No _____
If so, please briefly explain your likes and dislikes: _____
_____

Please List **ALL** current medications, the condition it's related to, and the dosage (Only list supplements that are prescribed by your physician):

NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____
NAME: _____ CONDITION: _____ DOSAGE: _____

If more space is needed, please use the back of this application and indicate here
Medications one back; □ yes □ no

Do you have any Allergies to Medications? □ yes □ no
If yes please list:

_____ _____
_____ _____

Do you have any Allergies to Foods or Environment? □ yes □ no
If yes please list:

_____ _____
_____ _____

In spite of the fact that you may not be a health care specialist, in your own words and in your own opinion, what do you think the real problem is? _____
_____

In Reference To Your Main Problem How Often Are You Aware of This Problem? (circle one)

Occasionally (25% of the time) Intermittently (50% of the time)
Frequently (75% of the time) Constant (80-100% of the time)

Would you consider this problem (circle one):

MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing significant limitations and/or concern)
EXTREME (Causing near constant (> 80% of the time) limitations)

Rate your desire to fix this problem: (1= minimal desire; 10 = highest possible desire.) 1 2 3 4 5 6 7 8 9 10

What are you hoping to hear / learn during your consultation? _____
_____

Please check any of the following that may apply to you:

❒ Abdominal Aortic Aneurism ❒ Severe Bleeding or Anticoagulant Therapy ❒ Pacemaker/Defibrillator
❒ Severe Bone Loss ❒ Acute Infections ❒ Benign Bone Tumors ❒ Fractures or Dislocations
❒ Vascular Insufficiencies ❒ Hardware or Metal Implants ❒ Pain Control Devices
❒ Cholesterol Medications

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

Race (check one):
□ African American □ American Indian □ Asian □Black □Native American □Pacific Islander □ White

Ethnicity (check one):
□ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: _____

Smoking/ Tobacco Status (check one):
_____ Current Every Day Smoker _____ Current Some Day Smoker
_____ Former Smoker/ Tobacco User _____ Never Smoked/ Used Tobacco

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I, _____, have completed all questions honestly and to the best of my knowledge. I understand that no treatments will be rendered until we understand completely whether your condition is a good fit for our treatments and you are comfortable with our clinical approach.

If you are accepted as a patient we will clearly help you understand your responsibility for services rendered. In cases where someone has insurance benefits, patients are responsible for deductibles and copays that their insurance

requires as well as any services not covered under their policy. For those without insurance or limited coverage, that is not a problem. We have easy and affordable payment options for patients to get the care that you need.

Once we have enough information to determine whether or not you can be helped in our clinic we will spend all the time necessary to help you understand your condition and what options there are to help you get better, as well as those treatments or therapies that may be available to you even outside our facility.

Signature: _____ Date: _____