ROCHESTER CHIROPRACTIC CENTER____________________________________Dr. Chad Martin & Dr. Todd Shelton

Application for Treatment

Date__________

Name____Age_________Birthdate___/____/____

Address ____City____________ZIP________

Home Phone(___)____________ Work Phone(___)_____________ Cell Phone(____)_________________

Referred to our office by _______________________________E-Mail Address________________________

Check if you are: Married____Single____Widowed____Divorced____Separated_____Social Security:_____________

Employer ____ Occupation ______________________

Company Phone and Address:

Who to contact in case of an emergency? ______________________Phone___________Relationship__________

Please describe the principal health problems for which you came to this office. ____________________________

____

____

____

How and when did symptoms first occur? ____

List any other doctors seen for these problems ____

List diagnosis(es) and type of treatment(s) ____

____

Does this interfere with your normal living and work? Yes____No____ In what way? ____________________

Have you lost any days of work? Yes____ No____ Dates______________________________________

Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain ____________________

____

List the names of any relatives that have or have had a similar problem _____________________________

____

Who is responsible for your bill? Self ____ Spouse____ Employer____ Insurance____ Other_____________

How payment will be made: Type of Insurance:

____________ Cash ____________ Worker's Compensation ____________ Health Insurance

____________ Check ____________ Credit Card ____________ Automobile Ins. Policy

PERSONAL HISTORY

Has a physician treated you for any health condition in the last year? Yes____ No____

If yes, explain: ____

____

Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain ______________

____

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)

____

____

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) ____________

____

____

ROCHESTER CHIROPRACTIC CENTER_______________________________Dr. Chad Martin & Dr. Todd Shelton

FAMILY INFO

Name of wife or husband ____ Ages of children ____________________
Spouse's Phone _______________________________
Your Nearest Relative __________________________ Relationship _____________________
Relative's Phone_______________________________

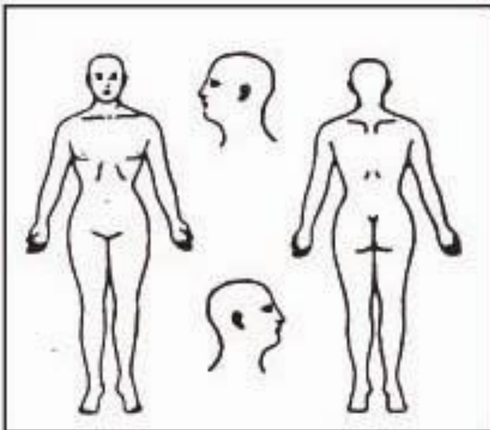
FAMILY HISTORY

Parents: Father (age)_______________ Mother (age)________________ Children (B)____________ (G)___________
Family Diseases: TB_______ Cancer__________ Mental Illness_________ Diabetes___________ Asthma__________
Heart Disease_______ Stroke______ Kidney Disease______ Lung Disease______ Arthritis______ Liver Disease_____

PERSONAL HISTORY

Childhood Diseases: Measles_______ Mumps_______ Chickenpox________ Other_____________________________
Unusual Childhood Diseases____
Adult Illnesses, Conditions or Injuries/Hospitalizations____
Surgeries____
Fractures____
Prescrip. Medications _______________________________Medication Allergies________________________________
Drugs/OTC Meds___________________ Smoke____________ Drink____________ Supplements_________________
Last Physician (MD/DO) (Date)___________ Who/Findings____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. ____
2. ____
3. ____
4. ____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. ____
2. ____
3. ____
4. ____

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.
I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient ____Date:___________________________
Patient Name Printed__________________________________ Guardian(If applicable)____________________________

PATIENT HEALTH QUESTIONNAIRE

Name____ Date ______________________________

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight Gain Loss
☐	☐	Angina
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast Soreness Lumps
☐	☐	Cancer, Explain_______________
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema (chronic lung disorders)
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Headache ______
☐	☐	Heart Attack (date)
☐	☐	Heartburn/Indigestion
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Disorders (by condition)
☐	☐	Kidney Stones
☐	☐	Liver/Gallbladder problems
☐	☐	Loss of Appetite

Past	Present	Condition
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Mid Back Pain
☐	☐	Muscular In-coordination
☐	☐	Neck Pain
☐	☐	Pain in Ankle or Foot
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Upper Arm or Elbow
☐	☐	Pain in Upper Leg or Hip
☐	☐	Painful Urination
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain
☐	☐	Stroke (Date)_____________
☐	☐	Swelling, Stiffness of Joint(s)
☐	☐	Tinnitus (Ear Noises)
☐	☐	Tumor, Explain___________
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Wrist Pain
☐	☐	Other___________________

Have You or Your Family Had:

Yes	**No**	
☐	☐	Cancer
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Chronic Back Problems
☐	☐	Heart Problems
☐	☐	Chronic Headaches
☐	☐	Lung Problems
☐	☐	High Blood Pressure
☐	☐	Lupus

Do you have a permanent disability rating? Yes__ No__

Location_______________________________________

Date rating received ? Rating Percentage__________

Please check any of the following that apply to you

Past	Present	
☐	☐	Pregnancy,# births____________
☐	☐	Birth control pills, Type________
☐	☐	Drug or Alcohol Dependence

Past	Present	
☐	☐	Tobacco___ packs/day
☐	☐	Alcohol __drinks/day/week/month
☐	☐	Coffee/Tea/Caffeinated Soft drinks
☐	☐	______cups/cans per day

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

____ ___________________________

Signature **Date**

Present Weight _______ Height: Feet _______Inches_______ Blood Pressure_____/_____Pulse______