PATIENT APPLICATION FOR TREATMENT

Last name:	First:	MI:	Gender ☐ M ☐ F
Email address:	Date of Birth:	Age:	
Your address:	City:	State:	
Zip:	SS#:	Home #	Cell #
Your Occupation?	Wk #		
Marital status? Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐			
Emergency Contact?	Emergency Phone #		
How many children do you have? What are their ages?			
Have you ever had chiropractic care? ☐ Yes ☐ No How long has it been?			
Has anyone else in your family ever had chiropractic care? ☐ Yes ☐ No			
Do you smoke: ☐ Yes ☐No How much?	Do you exercise: ☐ Yes ☐ No How much?		
What is the purpose or reason for this appointment?			
When do you notice it most? ☐ AM☐ PM	Have you ever had this in the past? ☐ Yes ☐ No		
What makes it feel better?	What makes it feel worse?		
(Females only) Are you pregnant? ☐ Yes ☐ No			

Using the scale below, indicate the **severity** of your **main complaint** (when at its worst)

None		**Slight**		**Mild**		**Moderate**			**Severe**
1	2	3	4	5	6	7	8	9	10

Using the scale below, indicate the **percentage of time** you experience your **main complaint**:

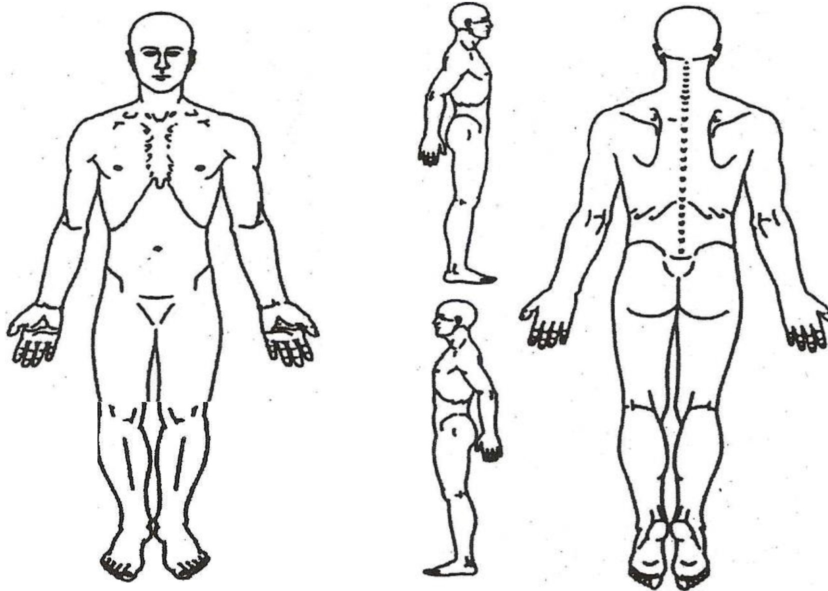
		Occasional		**Intermittent**		**FREQUENT**			**CONSTANT**	
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint**?

Does it bother you during: Personal Care Lifting Sleep Walk Social Life Concentrating Work Drive Sit Stand Recreation

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ACHE **B:** BURNING PAIN **C:** CRAMPING **D:** DULL PAIN **R:** THROBBING PAIN **N:** NUMBNESS **T:** TINGLING



SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) all conditions you are currently experiencing, or with a (P) the conditions you have had in the past. If neither apply, mark (NA). Please complete all lines without leaving any blanks.

Condition			
High Blood Pressure	☐C	☐P	☐NA
Dizziness/Fainting	☐C	☐P	☐NA
Insomnia	☐C	☐P	☐NA
Weak Immune System	☐C	☐P	☐NA
Tension	☐C	☐P	☐NA
Confusion	☐C	☐P	☐NA
Fatigue	☐C	☐P	☐NA
Ulcers	☐C	☐P	☐NA
Eye/Vision Problems	☐C	☐P	☐NA
Ear/Hearing Problems	☐C	☐P	☐NA
Difficulty Breathing	☐C	☐P	☐NA
Heart Problems	☐C	☐P	☐NA
Loss of Bladder Control	☐C	☐P	☐NA
Constipation	☐C	☐P	☐NA
Diarrhea	☐C	☐P	☐NA
Digestion Problems	☐C	☐P	☐NA
Nausea	☐C	☐P	☐NA
Female Problems	☐C	☐P	☐NA
Prostate Problems	☐C	☐P	☐NA
Diabetes	☐C	☐P	☐NA
Cold Hands/Feet	☐C	☐P	☐NA
Hand Tremors	☐C	☐P	☐NA
Loss of Memory	☐C	☐P	☐NA
Nervousness	☐C	☐P	☐NA
Sweaty Palms	☐C	☐P	☐NA
Speech Difficulty	☐C	☐P	☐NA
Anxiety	☐C	☐P	☐NA
Depression	☐C	☐P	☐NA
Irritability	☐C	☐P	☐NA

PLEASE CIRCLE ANY CURRENT OR PAST SYMPTOMS BELOW

Dr. Reviewed	Systems	Symptoms
_____	General	Weight changes, fatigue, anorexia, weakness, fever, chill, changes in activity
_____	Skin	Rashes, eruptions, changes in warts or moles, color changes, bruising, itching, hair loss, nail changes
_____	Head	Trauma, headaches, dizziness, light headed.
_____	Eyes	Change in acuity of vision, use of corrective lenses, double vision, intolerance to light, blurred vision, pain, excessive tearing, redness, discharge
_____	Nose	Excessive Mucous, Nose bleeds, allergies, airway obstruction
_____	Mouth & Throat	Ulcers, tooth pain/extractions, TMJ pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____	Neck	Stiffness, lumps/swelling/masses, pain
_____	Lungs	Cough (productive/nonproductive), coughing blood, shortness of breath, pain with breathing, wheezing, night sweats.
_____	Cardiac	Palpitations, chest pain, sleep propped up, paroxysmal nocturnal dyspnea, ankle swelling, fainting (syncope)
_____	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
_____	Breasts	Self-examination, frequency/results, pain, nipple discharge, lumps/masses, skin dimpling.
_____	Gastrointestinal	Unusual diet, difficulty swallowing, regurgitation, indigestion, nausea, vomiting, belching, abdominal pain, cramps, vomit blood, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
_____	Genitourinary	Urination (excessive, at night, infrequent), urgency, incontinence, urine color changes, blood in stool, sexually transmitted disease, painful sexual intercourse, scrotal mass (male), hernia
_____	Endocrine	Drink excessively, eat excessively, temperature intolerance, tremors, goiter, hair loss, excessive hair growth, menstruation history, pregnancy history, painful cycle, premenstrual syndrome
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain.
_____	Musculoskeletal	Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paraly-sis, tremors, ataxia, loss of balance, numbness
_____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT REC'D	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

☐ Reviewed External H P
☐ Release Records H P
☐ Request Records H P

External Dx'D: ____________
____

Disabilities:

Impairments:

Welcome To Our Office

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our policies is important of our professional relationship. Our office adheres to a strict "payment is due when services are rendered" policy.

- **Limited Release of Medical Information**: I authorize this Chiropractic office to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.
- **Insurance Patients**: I understand that my health insurance is a contract between the insurance carrier and myself. I understand that I am ultimately responsible for any fees for services rendered that are not covered by my insurance company. I agree to pay my portion of fees at the time of treatment is rendered. I authorize my insurance company to release any information required to process my claims. I understand that this office accepts billing for individual or group policies, personal injury cases, authorized worker's compensation and Medicare.
- **Missed Appointments**: In the event I am accepted for care in this office, I understand that it is vital to adhere to the recommended treatment plan. As a courtesy to others and to improve your results, our office has the following **missed appointment policy: 1st offense: warning, 2nd offense: $25 fee. **Massage appointments require a 24 hour notice of cancellation****
- **Nonpayment**: Please be aware if your account becomes delinquent we may refer you to a collection agency. In this event, all collection agency fees and/or legal fees and any unpaid balance would be your responsibility.
- **No Guarantee of Results**: I recognize that this office cannot guarantee the results of my health and that it is based upon my cooperation and my body's ability to recover.
- **Promotions and Discounts**: I understand that this office may attempt to assist me in my financial obligations for care needed by offering a promotion or discounted program by allowing me to prepay or agree to a budget plan for my care. In the event I decide to not follow the recommendation for this care, I agree and understand that I would be liable for whatever services were rendered at the office's normal fee.
- **HIPPA Acknowledgement**: I have had the opportunity to read the HIPPA policies of this office.

I have read and understand the payment policies listed above and agree to abide by its guidelines:

Patient Name (please print) ____ Date: ________________

Signature of Patient or Responsible Party _________________________________ Date: ________________

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.