Patient Application

Name : _____

Address: _____ City: _____ State:____ ZIP: _____

Cell#:_____ Home #: _____ Email: _____

Social Security No: _____ Birth date: _____ Age: _____

Height: _____ Weight: _____ Marital status (circle one): Single / Mar / Div / Sep / Widow

Occupation: _____ Employer: _____

Who may we thank for referring you? _____

Insurance? □ No □Yes
Insured Name: _____
Insured Date of Birth: _____

Medical Care Information:
Previous Chiropractic Care: □ No □Yes Name of Doctor: _____
Address: _____ City: _____ State: _____ ZIP: _____
Date of last visit: ____/____/____ Date of last Exam: ____/____/____
Family Doctor: □ No □Yes Name of Doctor: _____
Address: _____ City: _____ State: _____ ZIP: _____
Date of last visit: ____/____/ ____ Date of last exam: ____/____/____
Current Medications I am taking: _____; □ None
Have you had any surgeries? □ No □Yes If yes, Last Surgery Date: ____/____/____
Reason for Surgery: _____
Previous Accidents: □ Motor Vehicle/ Auto; □Work; □ Sports; □ None; □ Other: _____
When: _____ Describe: _____

Current Health/ Conditions:

□ Arthritis	□ Cancer	□ Heart Problems	□ Pacemaker	□ None
□ Asthma	□ Diabetes	□ High Blood Pressure	□ Scoliosis	

Other: _____

Family History of Illness:

_____
_____

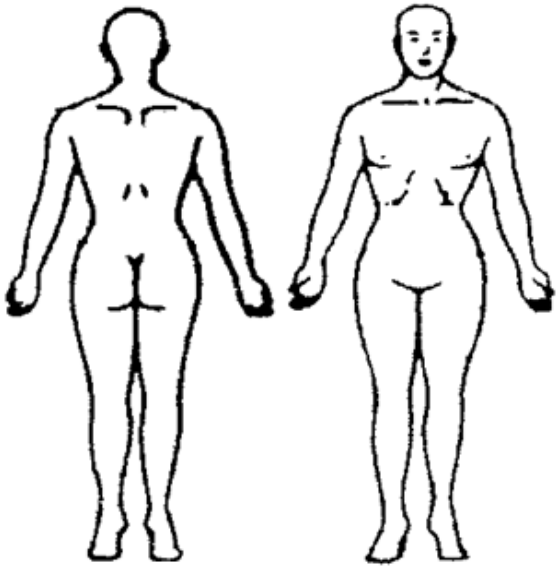
Social History:

Alcohol? □No □ Yes	Cigarettes? □ No □ Yes	Caffeine? □No □Yes	Exercise: □No □Yes Hours per week?___
Drinks per week? ___	Packs per day? ___	Drinks per day? ___	(Circle one) Light / Moderate / Strenuous

Signature: _____ Date: _____

CURRENT COMPLAINTS

Mark an "X" on the area(s) of complaints, and draw an "ᴧᴧᴧᴧ" if pain travels.



Reason for visit: _____

_____

Pain Ratings: □**0 ;** □**1 ;** □**2 ;** □**3 ;** □**4 ;** □**5 ;** □**6 ;** □**7 ;** □**8 ;** □**9 ;** □**10** (Severe)

Frequency (% of Day):

□ < 10% Rare**;** □Infrequent 10 % to 25% **;** □ Occasional 25% to 50% **;** □Frequent 50% to 75% **;** □ Constant >75%

When did symptoms start (Onset): _____

What makes it better? □ Medication □ Lying Down □ Standing □ Sitting □ Stretching □ Range of Motions □ Nothing

□ Other: _____

What makes it worse? □ Movements □ Bending □ Twisting □ Standing □ Walking □ Nothing
□ Pushing/Pulling □ Lifting □ Reading □ Working □ Driving

□ Other: _____

Radiating (Does Pain Travel to):

Upper Body: ___Shoulder ___Arm ___ Hand □ Left □ Right
Lower Body: ___ Hip ___Knee ___ Foot □ Left □ Right

Quality: □ Aching**,** □ Dull**,** □ Sharp**,** □ Stabbing**,** □ Throbbing**,** □ Numbness**,** □ Tingling

□ Other: _____

Timing at its worst: □ Morning**,** □ Afternoon**,** □ Evening**,** □ Over Night;
After Activities: □ Light □ Moderate

Associated with: □ Dizziness, □ Nausea, □ Visual Problems, □ Ringing/Buzzing ears,
□ Bright light, □ Sensitivity, □ Loss of balance, □ Other: _____

Signature: _____ Date: _____