

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT LEGIBLY.**

Today's Date _____

Name _____ E-Mail Address _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Current Age _____ Birth date _____ Marital Status: S M D W Number of Children _____

Your Social Security # _____ Driver's License STATE _____ # _____

How do you intend to pay for your appointments: Cash Check Credit Card Auto Insurance Claim

Do you have Medicare? Yes ___ No ___ If YES, what is your Medicare #? _____

Your Employer _____ Occupation _____ Appx Years On Job _____

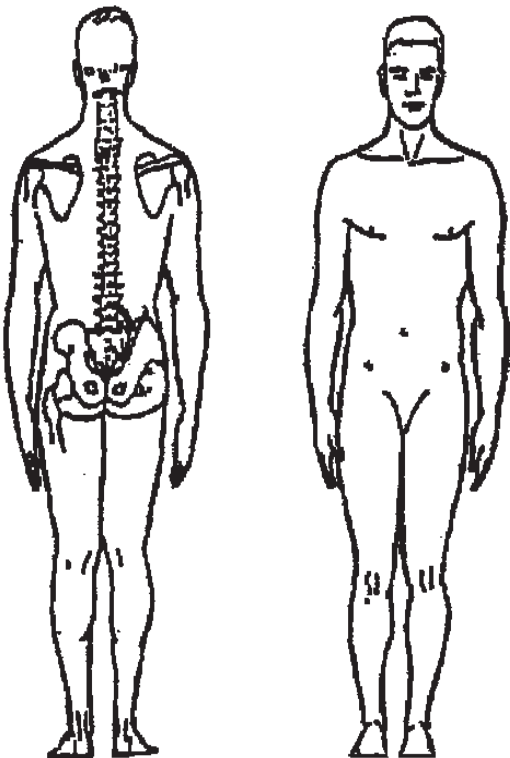
Employer Address _____ City _____ State _____ Zip _____

Name of Spouse, Parent or emergency contact _____ Their Birthdate _____

Spouse/Parent/EC Employed By _____ Occupation _____ Years On Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Who referred you? _____



COMPLETE THESE QUESTIONS AND DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram **to your left**. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR ISSUES

(Please list any condition you are being treated for or are experiencing.)

Are your conditions due to an accident? Yes No Date? _____

Type of accident? Automobile Work/Job Home Other: _____

Date(s) of auto accidents? Past Year 1-5 Years 5+ Years Never

Patient Name (please print) _____

Date _____

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL F – FREQUENT C – CONSTANT (NEVER – LEAVE BLANK!)

O	F	C		O	F	C		O	F	C	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distension of abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia (nerve pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental Decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
			Pain or numbness in:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control kidneys
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far sightedness				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble				FOR WOMEN ONLY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or backache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal symptoms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries				Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Malaria	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fever blisters	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mumps	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chorea	<input type="checkbox"/> Gout	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cold sores	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Influenza	<input type="checkbox"/> Polio	

Patient Name (please print) _____

Date _____

What is your major complaint? _____

List surgical operations and years: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills Tranquilizers Birth control pills
 Others: _____

Age of mattress: _____ Comfortable Uncomfortable

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports

Have you ever had any mental or emotional disorders? Yes No When diagnosed? _____

Have others in your family had such disorders? Yes No Appx age diagnosed? _____

HAVE YOU EVER:

Yes No

DESCRIBE BRIEFLY

- Been knocked unconscious Yes No _____
- Used a cane, crutch or other support? Yes No _____
- Been treated for a spine or nerve disorder? Yes No _____
- Had a fractured bone? Yes No _____
- Been hospitalized for anything other than surgery? Yes No _____

DO YOU:

- Currently take vitamins or minerals regularly? Yes No _____
- Think you may need vitamins or minerals? Yes No _____
- Have an allergy to any drug? Yes No _____

DATE OF LAST:

Less than 6 mo

6-18 months

18+ months

Never

Spinal examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental x-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

Heavy

Moderate

Light

None

Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IN CASE OF EMERGENCY: (Name of relative or close friend **not living in your home, but living locally**):

NAME _____ CITY: _____ PHONE: _____