

Take Care chiropractic

Life Wellness Center

PATIENT APPLICATION FOR CARE

Today's Date _____

Hello, ***please read and complete this questionnaire in detail.*** Please do not leave any blanks, simply put n/a if a question does not apply to you. Your answers will help us determine if Chiropractic Care can assist you. If we do not believe your condition will respond, we will not accept your case.

A caring family member or friend refers most patients to our office, whom may we thank for referring you to our office?

PERSONAL INFORMATION

Name: First _____ MI _____ Last _____
How would you like to be addressed? _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail Address: _____ DOB: ___/___/___ Age: _____ SSN: _____-_____-_____
Occupation: _____ Employer: _____
Marital Status: S M W D Significant Other's Name: _____
Emergency contact: _____ Phone: _____
Children's Name & Ages: _____

HEALTH HISTORY

Have you ever had Chiropractic Care? Y / N How long has it been? _____

Have any members of your family received Chiropractic Care? Y / N Who? _____

Research shows that your spine should be checked regularly. When was your last spinal examination, including x-rays? _____

What is the purpose/reason for this appointment? _____

How often do you drink alcoholic beverages? _____ Do you smoke? Y / N How much? _____

Do you exercise? Y / N How often? _____ What type? _____

Do you have any allergies? (specify) _____

Have you **ever** suffered from or been diagnosed as having: (circle yes or no for each)

Y / N Cancer	Y / N HIV Positive	Y / N Rheumatoid Arthritis
Y / N Broken or fractured bones	Y / N Gall Bladder	Y / N Ruptures
Y / N Osteoarthritis	Y / N A Congenital Disease	Y / N Depression
Y / N Eating Disorder	Y / N Seizures/Convulsions	Y / N High/Low Blood Press.
Y / N Circulatory Problems	Y / N Excessive Bleeding	Y / N Coughing Blood
Y / N Epilepsy	Y / N Ulcers	Y / N Tumors
Y / N Alcoholism	Y / N Pacemaker	Y / N Drug Addiction
Y / N Strokes	Y / N TMJ/Head problems	Y / N Diabetes

If yes, please explain _____

Have you ever been hospitalized? Y / N If yes, please explain _____

Have you ever had surgery? Y / N If yes, please explain _____

When was your last physical exam? _____ By whom? _____

When was the last time you were involved in an accident of any kind? _____

Do you ever take Over the Counter Medicine? Y / N Do you ever take Prescription Medicine? Y / N

What type/s _____ What type/s _____

How long? _____ How long? _____

How much? _____ How much? _____

Do you ever take Supplements? Y / N Do you ever take anything else? Y / N

What type/s _____ What type/s _____

How long? _____ How long? _____

How much? _____ How much? _____

SYSTEMS REVIEW

In the *left hand* column, please indicate with a
(C) Conditions that you have now or with a
(P) Conditions you have had in the past.

If neither apply, mark (NA),
 Please don't leave any blanks.

- ___ High Blood Pressure
- ___ Dizziness/Fainting
- ___ Insomnia
- ___ Low Resistance
- ___ Tension
- ___ Confusion
- ___ Fatigue
- ___ Ulcers
- ___ Eye/Vision Problems
- ___ Ear/Hearing Problems
- ___ Difficulty Breathing
- ___ Heart Problems
- ___ Constipation
- ___ Diarrhea
- ___ Digestion Problems
- ___ Nausea
- ___ Female Problems
- ___ Prostate Problems
- ___ Diabetes
- ___ Loss of Memory
- ___ Hands/Feet cold
- ___ Sweaty Palms
- ___ Hand Tremors/Pain
- ___ Anxiety
- ___ Depression
- ___ Irritability
- ___ Jaw pain
- ___ Headaches

FOR DOCTOR'S USE ONLY

Dr. Reviewed system	Body Signals
___ General.....	Weight changes, fatigue, anorexia, fever, chills, changes in activity
___ Skin.....	Rashes, changes in warts/moles/pigmentation, itching, bruising, hair loss
___ Head.....	Trauma, headaches, dizziness, light headed
___ Eyes.....	Change in vision, blurred, redness, scotomata pain, excessive lacrimation
___ Nose	Rhinorrhea, epistaxis, allergies, airway obstruction
___ Mouth/Throat.....	Ucers, tooth pain, TMJ, gum bleeding, soreness, enlarged glands, strep
___ Neck.....	Stiffness, lumps, swelling, masses, pain
___ Lungs.....	Cough, hemoptysis, dyspnea, pain, wheezing, night sweats
___ Cardiac.....	Palpitations, chest pain, orthopnea, nocturnal dyspnea, ankle swelling, fainting
___ Vascular.....	Raynaud's phenom, intermittent claudication, hypertension, rheumatic fever
___ Breasts.....	Self-exam frequency/results, pain, discharge, lumps/masses, skin dimpling
___ Gastrointestinal.....	Unusual diet, dyspepsia, nausea, vomiting, abdominal pain, cramps, hematemesis, bowel irregularity, jaundice, abdominal swelling
___ Genitourinary.....	Polyuria, nocturia, oliguria, dysuria, urgency, hematuria, STD, scrotal mass,dysparounia, hernia
___ Endrocine.....	Polydipsia, polyphagia, tremors, temp intolerance, goiter, alopecia, hirsuitism,menstration, pregnancy history, dysmeorrhea, PMS, climacteric
___ Hematopoietic.....	Anemia, abdominal bleeding, lymph node enlargement/pain
___ Muscoskelatal.....	Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weak,atrophy
___ Neurological.....	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis,loss of balance, numbness, paresthesia
___ Psychological.....	Mood swings, depression, anxiety, phobias

RECORDS REQUEST NEEDED

Notes _____

PROVIDER LIST

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

- Dr. Name/Facility _____
- Type of treatment received _____
- Dr. Name/Facility _____
- Type of treatment received _____
- Dr. Name/Facility _____
- Type of treatment received _____

- Condition _____
- From when to when _____
- Condition _____
- From when to when _____
- Condition _____
- From when to when _____

PATIENT HISTORY

What is your main complaint? _____

How long have you been experiencing your main complaint? _____

On the scale below, please circle the severity of your main complaint **at it's worst.**

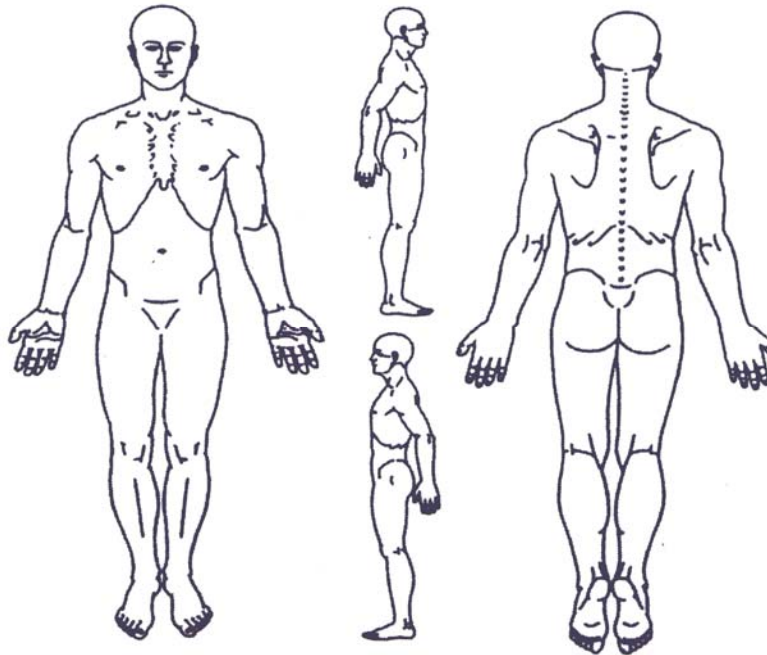
None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

On the scale below, please circle the **percentage of the time** you experience your main complaint:

	Occasional		Intermittent		Frequent		Constant			
0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

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

A: Ache **B:** Burning pain **C:** Cramping **D:** Dull pain **R:** Throbbing pain **N:** Numbness **T:** Tingling



When do you notice it the most? AM / PM _____ How long does it last? _____ Minutes _____ Hours _____ Days _____
 What makes it feel better? _____ What makes it feel worse? _____
 Have you ever had this problem in the past? Y / N _____ Have you ever received care for this problem in the past? Y / N _____
 If yes, by whom? _____ Have you lost time from work because of it? Y / N _____

Do you have pain and/or difficulty performing any of the following activities (circle):

- | | | |
|---------------|------------|-------------|
| Personal Care | Work | Walking |
| Lifting | Driving | Sitting |
| Reading | Sleeping | Standing |
| Concentrating | Recreation | Social Life |

Are you pregnant? Y / N _____ What was the first day of your menstrual cycle? _____
 Number of pregnancies? _____ Miscarriages? _____

Signature: _____ Date: _____