

TREATMENT APPLICATION

This treatment application is the first step in assisting the doctor in determining if you are a candidate for our non-surgical procedures, therapies and specialized treatment technology. Please answer the following questions honestly and to the best of your knowledge.

CONFIDENTIAL PATIENT INFORMATION

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ Date ____/____/____ S/S# ____-____-____
 First MI Last
 Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell Phone _____ Email _____
 Sex: Female Male Birth Date ____/____/____
 Status: Minor Married Single Divorced Widowed Separated
 Occupation _____ Please Explain Duties of Your Work _____
 Spouse/ Partner Name _____ Phone _____
 Person to contact in case of an emergency _____ Phone _____
 How were you referred to our office? _____
 Who is your Primary Care Physician? _____ Phone _____

HEALTH HISTORY

What type of regular exercise do you perform? (circle) None Light Moderate Strenuous Height: ____ft. ____in. Weight: _____lbs.

Do you currently have or have you previously had any of the following symptoms or conditions:

Past Present

- Headaches
- Neck Pain
- Neck Stiffness
- Mid Back Pain
- Low Back Pain
- Pain In Arm and/or Legs
- Burning on the Feet
- Pins and Needles in Arms
- Pins and Needles in Legs
- Numbness in Fingers
- Numbness in Toes
- Cold Hands and/or Feet
- Skin Sensitivity To Touch
- Nervousness
- Skin Disorders
- *Urine flow / bowel difficulties
- Hip Surgery/Injury

Past Present

- Tension
- Irritability and Stress
- Mood Swings
- Sleeping Problems
- Fatigue
- Depression
- Chest Pain
- Shortness of Breath
- Cold Sweats
- Fever
- Fainting
- Dizziness
- Loss of Balance
- Light Sensitivity w/Eyes
- Loss of Vision
- Chronic use of steroids
- Recent Spine Fracture

Past Present

- Ringing/ Buzzing in Ears
- Loss of Memory
- Loss of Smell
- Loss of Taste
- Upset Stomach
- Constipation
- Diarrhea
- Urinary Problems
- Heartburn
- Ulcers
- Allergies
- Menstrual Pain
- Menstrual Irregularity
- Hot flashes
- Intimacy/Sex-related
- *Cancer: _____
- Osteoporosis / Causing Fractures

Other Disorders:

Have **YOU** or **A FAMILY MEMBER** ever been diagnosed with any of the following conditions:

- AIDS/HIV/Hepatitis C
- Heart Disease
- Thyroid Disorders
- Cancer (in family)
- Diabetes
- Respiratory/COPD
- High Blood Pressure
- Stroke
- Other Medical

Conditions Not Listed: _____

Have you had MRI's taken? __ No __ Yes. Of **what part** of your body _____ When _____
 Where (what facility took them) _____ Did you bring your MRI report? _____

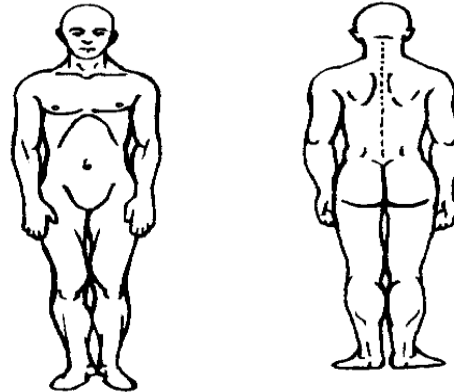
PLEASE LIST YOUR CURRENT PROBLEMS OR COMPLAINTS: (Chief complaint or present illness)

1) _____ 2) _____ 3) _____ 4) _____

What % of the day do these symptoms bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = ^^^^^
- Shooting = →
- Other _____ = ***



Please circle the appropriate number(s) for the intensity of your pain and the appropriate letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time)
F = Frequent (51-75%)

I = Intermittent (26-50%)
C = Constant (76-100%)

Area of Pain / Symptom & Intensity	Normal	Minimal	Slight			Moderate			Severe			Frequency			
			1	2	3	4	5	6	7	8	9	10	25%	50%	75%
Neck		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hands L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Legs L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Feet L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C

Is it worse in the morning or as the day progresses? _____

Does anything relieve your pain? _____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? Sitting Standing Walking Bending – Direction? _____ Lying Down Other _____

Describe on the scale how the pain has affected your work & activity (both inside and outside the home, and housework)

0 none 1 2 3 4 5 moderate 6 7 8 9 10 extremely

In General, how would you rate your overall health right now? Excellent Very Good Good Fair Poor

Please describe any other activities/hobbies that are restricted due to these symptoms? _____

When did you first notice these symptoms? _____ Is the condition getting worse? No Yes

Have you had this problem before? No Yes, When? _____

Have you had an injury or fall? No Yes, Describe _____

Have you been **diagnosed with herniated / bulging disc/ or another spine condition?** ___ Yes ___ No
 Describe: _____

Have you had Lab tests or Xray's for this condition? No Yes Where? _____ When? _____

What kinds of treatments have you received for the above condition (your chief complaint)?

Epidural:	How Many _____	When(approx) _____
Physical Therapy:	How Long _____	When _____
Medication:	_____	When _____
Medication:	_____	When _____
Medication:	_____	When _____
Surgery:	Type _____	When _____
	Type _____	When _____
Other Care:	_____	When _____
	_____	When _____
	_____	When _____

Did any of these treatments work? If so, which one(s)? For how long?

Past Chiropractic Care: Yes / No _____
 If so, please briefly explain your likes and dislikes: _____

In spite of the fact that you may not be a health care specialist, in your own words and in your own opinion, what do you think the real problem is? _____

In Reference To Your Main Problem How Often Are You Aware of This Problem? (circle one)

- | | |
|--------------------------------|----------------------------------|
| Occasionally (25% of the time) | Intermittently (50% of the time) |
| Frequently (75% of the time) | Constant (80-100% of the time) |

Would you consider this problem (circle one):

- MINIMAL (Annoying but causing NO limitations)
- SLIGHT (Tolerable but causing a little limitation)
- MODERATE (Sometimes tolerable but definitely causing limitations)
- SEVERE (Causing significant limitations and/or concern)
- EXTREME (Causing near constant (> 80% of the time) limitations)

Rate your desire to fix this problem: (1= minimal desire; 10 = highest possible desire.) 1 2 3 4 5 6 7 8 9 10

What are you hoping to hear / learn during your consultation? _____

Please check any of the following that may apply to you:

- Abdominal Aortic Aneurism Severe Bleeding or Anticoagulant Therapy Pacemaker/Defibrillator
- Severe Bone Loss Acute Infections Benign Bone Tumors Fractures or Dislocations
- Vascular Insufficiencies Hardware or Metal Implants Pain Control Devices
- Cholesterol Medications

For Women Only: Is there a possibility that you may be pregnant? No Yes

No treatments will be rendered until we understand completely whether your condition is a good fit for our treatments and you are comfortable with our clinical approach.

If you are accepted as a patient we will clearly help you understand your responsibility for services rendered. In cases where someone has insurance benefits, patients are responsible for deductibles and copays that their insurance requires as well as any services not covered under their policy. For those without insurance or limited coverage, that is not a problem. We have easy and affordable payment options for patients to get the care that you need.

Once we have enough information to determine whether or not you can be helped in our clinic we will spend all the time necessary to help you understand your condition and what options there are to help you get better, as well as those treatments or therapies that may be available to you even outside our facility.

Thank You