

Patient Application

Full Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Ph: _____ Work / Other Ph: _____ Email: _____

Gender: ☐ M ☐ F Age: _____ Birth Date: _____ SSN#: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation: _____ Employer: _____

Spouse Name: _____ Ph: _____

How did you hear about us? _____

CHIROPRACTIC EXPERIENCE

Have you seen a Chiropractor before? ☐ YES ☐ NO When? _____

Reason for previous chiropractic care? _____

Have you seen anyone for this condition? ☐ YES ☐ NO If so, who? _____

Have you had: ☐ X-rays ☐ MRI ☐ CT-Scan ☐ None Where? _____

PURPOSE FOR THIS VISIT

Are your present problems due to an injury? ☐ YES ☐ NO Enter the date of the injury: _____

Was the injury: ☐ Job Related ☐ Auto Accident ☐ Personal Injury ☐ Other: _____

Please describe the **three most important symptoms** you are experiencing.

Begin with your **FIRST SYMPTOM** below; additional symptom sections are provided on the following page:

1. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain: ☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent ☐ None

Type of Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Stinging ☐ Throbbing ☐ None

Indicate the area your symptom radiates to: _____ Side: ☐ Left ☐ Right

What makes it worse: _____

What makes it better: _____

How long have you had the symptom (1 day, 1 month, etc): _____

When does the pain occur? (constant, morning, etc): _____

FOR OFFICE USE ONLY

Account # _____ 1 2 ☐ Acct/Folder ☐ WellScore ☐ Cond/Diag ☐ ROF ☐ Outcome ☐ Ins/Bill ☐ Scanned

Please describe the **SECOND SYMPTOM** you are experiencing:

2. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain: ☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent ☐ None

Type of Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Stinging ☐ Throbbing ☐ None

Indicate the area your symptom radiates to: _____ Side: ☐ Left ☐ Right

What makes it worse: _____

What makes it better: _____

How long have you had the symptom (1 day, 1 month, etc): _____

When does the pain occur? (constant, morning, etc): _____

Please describe the **THIRD SYMPTOM** you are experiencing:

3. _____ (1) Very Mild (2) (3) (4) (5) (6) (7) (8) (9) (10) Remarkably Severe

Frequency of Pain: ☐ Constant ☐ Occasional ☐ Intermittent ☐ Frequent ☐ None

Type of Pain: ☐ Aching ☐ Burning ☐ Dull ☐ Pulling ☐ Sharp ☐ Shooting ☐ Stabbing

☐ Stinging ☐ Throbbing ☐ None

Indicate the area your symptom radiates to: _____ Side: ☐ Left ☐ Right

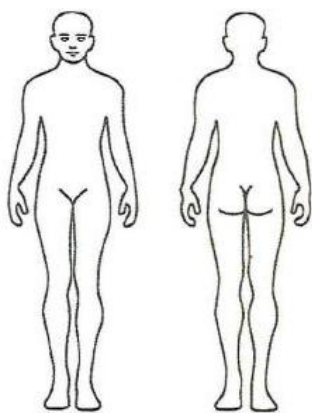
What makes it worse: _____

What makes it better: _____

How long have you had the symptom (1 day, 1 month, etc): _____

When does the pain occur? (constant, morning, etc): _____

SYMPTOM DETAILS



1. Have you received any past treatments for these symptoms? ☐ YES ☐ NO

If yes, please describe: _____

2. Please **circle the areas on the diagram** on the left where you are experiencing the symptoms described.

3. Is this condition: ☐ Improving ☐ Worsening ☐ Staying the same

4. Is this condition: ☐ Constant ☐ Intermittent ☐ Activity Related

5. Does it interfere with: ☐ Work ☐ Sleep ☐ Exercise ☐ Hobbies

☐ Daily Routine ☐ Self-Care ☐ Other: _____

6. Past traumas and injuries – List any past traumas and injuries you have had: _____

7. Do you suffer from any other health conditions? _____
8. Please list any medications: _____
9. Please list any surgeries you have had and their approximate dates: _____
10. Are you aware that poor posture has a negative impact on your health? ☐ YES ☐ NO
11. Have you noticed that you carry your head forward or that your shoulders are rounding? ☐ YES ☐ NO
12. Are you aware of any poor posture habits you may have? ☐ YES ☐ NO

HEALTH CONDITIONS

1. Cervical Spine (Neck): Are you experiencing any of the following symptoms?

- ☐ Neck pain ☐ Headaches ☐ Sinusitis ☐ Dizziness ☐ Loss of balance ☐ Neck stiffness ☐ Tension
- ☐ Pain in shoulders/arms/hands → ☐ Left ☐ Right
- ☐ Numbness tingling arms/hands → ☐ Left ☐ Right
- ☐ Weakness in grip → ☐ Left ☐ Right

2. Thoracic Spine (Upper Back): Are you experiencing any of the following symptoms?

- ☐ Upper back pain ☐ Pain on deep inhaling/exhaling ☐ Chest pain ☐ Pain between shoulders

3. Thoracic Spine (Mid Back): Are you experiencing any of the symptoms?

- ☐ Mid back pain ☐ Pain into your ribs/chests ☐ Indigestion/Heartburn

4. Lumbar Spine (Low Back): Are you experiencing any of the following symptoms?

- ☐ Low back pain ☐ Pain in your hips/legs/feet → ☐ Left ☐ Right
- ☐ Numbness/tingling/weakness in legs/feet/hips → ☐ Left ☐ Right
- ☐ Muscle cramps legs/feet → ☐ Left ☐ Right

HEALTH GOALS

Do you exercise? ☐ None ☐ Moderately ☐ Daily

When do you expect to get relief? _____

When do you expect complete resolution/results? _____

What do you think would happen with your condition if you do nothing? _____

Signature of Patient / Guardian: _____ **Date:** _____

Emergency Contact: _____ **Relationship:** _____ **Ph:** _____