PATIENT APPLICATION FOR TREATMENT

TODAY'S DATE: ______________ ACCT # ______________

NAME: ______________ HOW WOULD YOU LIKE TO BE ADDRESSED? ______________

DATE OF BIRTH: ______________ AGE: ______________ GENDER: ______________

YOUR ADDRESS: ______________ CITY: ______________

STATE: ______ ZIP: ______ SS #: ______________ HOME #: ______________

YOUR OCCUPATION: ______________ WK #: ______________ CELL #: ______________

EMERGENCY CONTACT ______________ PH #: ______________

MARITIAL STATUS S M W D EMAIL: ______________ REFERRED BY: ______________

HOW MANY CHILDREN DO YOU HAVE? ______________ WHAT ARE THEIR AGES? ______________

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ❑ Yes ❑ No

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑ Yes ❑ No HOW LONG SINCE LAST VISIT? ______________

THE PURPOSE OR REASON FOR THIS APPOINTMENT? ______________

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? ______________

DO YOU SMOKE? ❑ Yes ❑ No HOW MUCH? ______________

DO YOU EXERCISE? ❑ Yes ❑ No HOW OFTEN? ______________ 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	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

* Explanation: ______________

____

____

____

WHEN WAS YOUR LAST PHYSICAL EXAM? ______________

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? ______________

FOR DOCTOR'S USE ONLY

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S

DATE: ____________

ACCT: ________________

PATIENT: ______________________________

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), 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 ____
Loss of Bladder Control ____
Constipation ____
Diarrhea ____
Digestion Problems ____
Nausea ____
Female Problems ____
Prostate Problems ____
Diabetes ____
Hands/Feet Cold ____
Hand Tremors ____
Loss of Memory ____
Nervousness ____
Sweaty Palms ____
Speech Difficulty ____
Anxiety ____
Depression ____
Irritablility ____

FOR DOCTORS'S USE ONLY

DR. REVIEWED	SYSTEMS
____	General
____	Skin
____	Head
____	Eyes
____	Nose
____	Mouth & Throat
____	Neck
____	Lungs
____	Cardiac
____	Vascular
____	Breasts
____	Gastrointestinal
____	Genitournary
____	Endocrine
____	Hematopoietic
____	Musculoskelatal
____	Neurological
____	Psychological

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

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

DATE: ____________

ACCT: ________________

PATIENT: ____________________________

PATIENT HISTORY

1. What is your **main complaint**? ____________________________
2. On the scale below, please circle the **severity** of your **main complaint** (At it's worst)

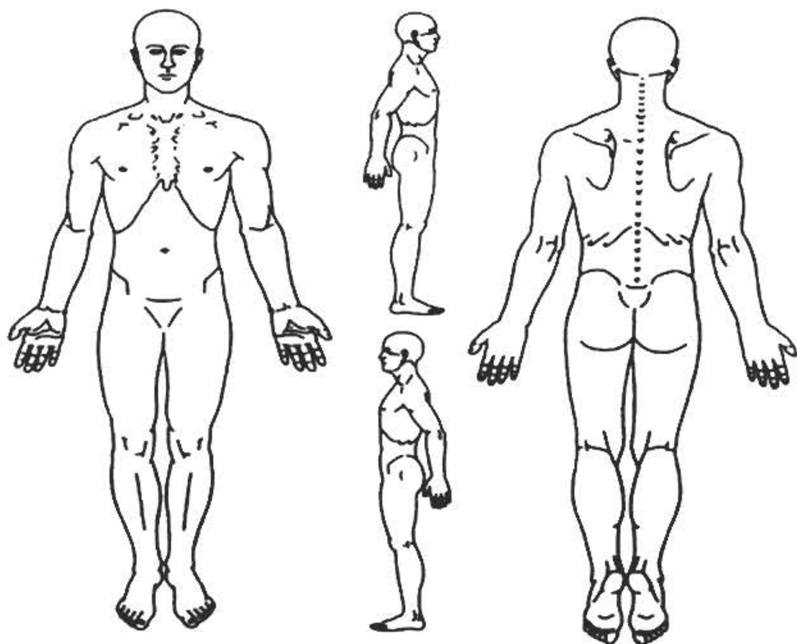
None		***Slight***		***Mild***		***Moderate***			***Severe***
1	2	3	4	5	6	7	8	9	10

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

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

4. How **long** have you been experiencing your **main complaint?** ________
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T**: tingling



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

personal care ____

lifting ____

reading ____

concentrating ____

work ____

driving ____

sleeping ____

recreation ____

walking ____

sitting ____

standing ____

social life ____

Signature: ________________

Date: ____/____/____

6. When do you notice it most? ☐ AM ☐ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? ______________________________
8. What makes it feel worse? ______________________________
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ been hospitalized ☐ been treated by another chiropractor ☐ been treated by another specialty provider ☐ never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No
    Dates? ____________ to ____________
12. Are you pregnant? ☐ Yes ☐ No
13. What was the first day of your last menstrual cycle? ____________
14. Number of pregnancies? ________ Miscarriages? ____________

Employment Information

Business Name: ____________________________________ **Occupation/Job Title:** __________________________
Business Address: __________________________________ **Name of Supervisor:** ___________________________

Business Phone: (__________) _________-__________ **Type of Work:** _________________________________

Insurance Information:
Who Is Responsible For Your Bill? YOU and… (Mark appropriate box (es)) ☐ **Myself ONLY**

☐ **Spouse** ☐ **Worker's Comp** ☐ **Auto Insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Other (be specific):**______________

Personal Health Insurance Carrier: __________________ **Health ID card #:** _____________________________

Policy Holder's Name: _____________________________ **Group #:** ____________________________________

Policy Holder's Social Security #: ______-_____-_______ **Primary Care Physician:** _______________________

Workers Compensation Injury / Auto / Personal Injury:

Have you filed an injury report with your employer? ☐**Yes** ☐ **No** **Date:** ____/____/______**Time:** _______**am/pm**

Carrier: ____ **Policy #** _______________________________

Carriers Phone #: (_______) ___________-_______________ **Adjuster:** _______________________________

Claim #: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to treat my condition as he or she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the Doctor, is for x-ray interpretation and for examination only. The x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: ___________________________ **Patient's Signature:** _________________________ **Date:** ________
Consent to treat a Minor: ________________________________ **Date:** _____________
Guardian or Spouse's Signature of Authorizing Care: _________________________________ **Date:** _____________

I acknowledge that I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: ____ **Date:** _____________
Patient's Signature: ____ **Date:** _____________

Please List your Primary Care Physician

Doctor: ____
City, State: ____
Phone #: ____

I authorize Pure Wellness Chiropractic to contact my Primary Care Physician as a courtesy call to inform them of my care.

Patient's Signature: ____ **Date:** _____________