MR#:_____ ☐ R O P

PATIENT APPLICATION FOR CHIROPRACTIC CARE

NAME: (First)_____ (Last)_____ TODAY'S DATE:_____

WHAT NAME (NICKNAME) WOULD YOU LIKE TO BE CALLED? _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

DATE OF BIRTH:_____ AGE:_____ M / F Height_____ Weight_____

YOUR ADDRESS:_____APT # _____ HOME PHONE:_____

CITY/STATE/ZIP: _____ MOBILE PHONE:_____ PROVIDER: _____

YOUR OCCUPATION:_____ WORK PHONE:_____

EMPLOYER:_____ EMAIL (please print): _____

ADDRESS/LOCATION:_____ CITY/STATE/ZIP: _____

SPOUSE'S/PARTNER'S NAME:_____ HOW MANY CHILDREN DO YOU HAVE?_____

OCCUPATION:_____ WHAT ARE THEIR AGES?_____

HAVE YOU EVER HAD CHIROPRACTIC CARE? ☐ YES ☐ NO HOW LONG HAS IT BEEN?_____

(Optional) WHAT DID YOU LIKE or DISLIKE ABOUT THE CHIROPRACTIC CARE? _____

DO YOU EXERCISE? ☐ YES ☐ NO HOW OFTEN?_____TYPE:_____

ANY ALLERGIES: _____

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

☐ DAYS ☐ WEEKS ☐ MONTHS ☐ YEARS

DETAILS: _____

DID/DO YOU PLAY ANY SPORTS? ☐ YES ☐ NO

ANY MEMORABLE HITS EVEN IF NO PAIN? (DETAILS) _____

_____

HAVE YOU BROKEN ANY BONES, EVEN HANDS or FEET? ☐ YES ☐ NO

(DETAILS) _____

HAVE YOU HAD ANY BAD SLIPS or FALLS? ☐ YES ☐ NO

(DETAILS) _____

HAVE YOU HAD ANY SURGERIES? ☐ YES ☐ NO

(DETAILS) _____

TYPES OF PHYSICAL or STRESSFUL JOBS? ☐ YES ☐ NO

(DETAILS) _____

PROBLEMS LIST

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

LAST PHYSICAL EXAM DATE: _____

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☐ **REVIEWED EXTERNAL H P**
☐ **RELEASE RECORDS H P**
☐ **REQUEST RECORDS H P**
EXTERNAL
DX'D:_____

_____

DISABILITIES:

IMPAIRMENTS:

ORDERS:

☐ **STAT** ☐ **PENDING EXAM**
DIFFERENTIAL
DX_____

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Next Visit _____ **NPR** _____ **AM PM**

F to NPR _____ **SP Y N**

Misc. _____

INS _____ **MM Caid**

DR: _____

_____

_____

S.O.A.P.S._____ **MD REPORT**_____

Referral: _____

GFT CRD ☐ **P/C** ☐ ***init*** _____

PATIENT HISTORY H P I

WHAT IS YOUR CHIEF COMPLAINT? *(please circle):* ***HEAD, NECK, SHOULDER(S), ARM(S), MIDDLE BACK, LOWER BACK, HIP(S), LEG(S), OTHER:*** _____

WHEN DID THIS PROBLEM FIRST BEGIN?_____

WHEN DO YOU NOTICE IT MOST? ☐ AM ☐ PM **(TIMING)**

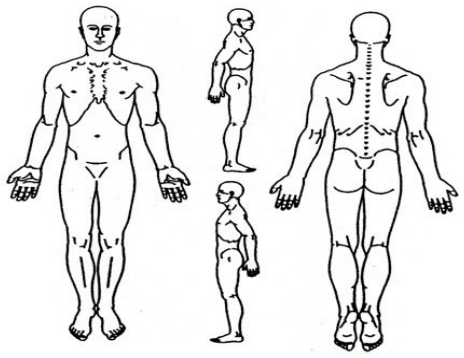
HAVE YOU EVER HAD THIS PROBLEM IN THE PAST? ☐ YES ☐ NO

HAVE YOU LOST TIME FROM WORK BECAUSE OF IT? ☐ YES ☐ NO
IF YES, PLEASE LIST DATES: _____

ON THE DIAGRAM BELOW, PLEASE SHOW WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS RELATED TO YOUR COMPLAINT. USE THE LETTERS TO REPRESENT WHAT TYPE OF PAIN.

QUALITY

A: ACHING
B: BURNING SENSATION
C: CRAMPING
D: DULL / THROBBING
M: MUSCLE
N: NUMBNESS
S: SHARP
T: TINGLING



LOCATION

MODIFYING FACTORS
WHAT ARE SOME OF THE THINGS YOU DO WHICH MAKE THIS FEEL BETTER? *(please circle):* ***ICE, HEAT, REST, MASSAGE, LYING DOWN, STANDING, SITTING, PAIN MEDS, OTHER:*** _____

PROVOCATIVE: SUBLUXATIONS CAN BE AGGRAVATED BY CERTAIN ACTIVITIES AND INCREASE PAIN. WHAT ARE SOME OF THE THINGS YOU DO WHICH MAKE YOU FEEL WORSE? (*please circle):* ***COMPUTER WORK, TURNING HEAD, SITTING, STANDING, BENDING, LIFTING, CLIMBING STAIRS, WALKING, REACHING, LAYING DOWN, OTHER:*** _____

HOW MANY MINUTES/POUNDS BEFORE IT WORSENS? _____MINUTES _____POUNDS

RADIATING: THE MORE SEVERE THE NERVES ARE CRUSHED, THE FURTHER THE PAIN TRAVELS FROM THE SOURCE OF THE PROBLEM. DOES THE PAIN RADIATE TO ANY OTHER AREA? *(please circle):* ***HEAD, SHOULDER, ARM, HIP, LEG, OTHER:*** _____

I AM EXPERIENCING PAIN/DISCOMFORT IN THE FOLLOWING EXTREMITIES:
(please circle): ***SHOULDER, ELBOW, WRIST, RIB CAGE, HIP, KNEE, JAW, OTHER*** _____

WHAT OTHER PROBLEMS DO YOU HAVE THAT YOU FEEL MAY BE RELATED TO YOUR PRIMARY PRESENTING PROBLEM? _____

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AREA/1^{o} Csp Tsp Lsp Ssp Psp _____

☐ ACUTE EXACERBATION
☐ SUDDEN ONSET
☐ PROGRESSIVE W/O OBVIOUS CAUSE
☐ PERSISTENT ☐ RECURRENT

RELATIONSHIP(S) TO FACTORS:
_____
☐ REFERRED
☐ UNRELATED
☐ CONSTANT
☐ INTERMITTENT

MECHANISM OF INJURY:
_____
_____

SEVERITY:
☐ MILD
☐ MODERATE
☐ MODERATELY SEVERE

EPISODIC PRESENTATION:
A_____ SA_____ CHRONIC_____

SYMPTOM STATUS:
☐ TASK RELATED_____
☐ DECREASING _____
☐ INCREASING_____

EFFECTS ON SOCIAL/WORK Hx:
SOCIAL_____
WORK_____
PERSONAL_____

IF WE CAN HELP, WHAT DO YOU WISH TO DO THAT IS NOW DIFFICULT OR IMPOSSIBLE? _____
_____

PAST FAMILY SOCIAL HISTORY - (PFSH)

DOES ANY MEMBER OF YOUR FAMILY SUFFER FROM THE SAME OR SIMILAR PROBLEMS? ☐ YES ☐ NO *(please circle):* ***DAUGHTER, SON, MOTHER, FATHER, SISTER, BROTHER, GRANDMOTHER, GRANDFATHER, OTHER:*** _____

MIGHT YOUR FAMILY HISTORY CONTRIBUTE TO ISSUE(S)? ☐YES ☐ NO ☐ Don't Know

EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING? ***(please circle)*** **Y (YES) N (NO) F (FAMILY)**

Y N F CIRCULATORY PROBLEMS
Y N F **RHEUMATOID ARTHRITIS**
Y N F SEIZURES/CONVULSIONS
Y N F A CONGENITAL DISEASE
Y N F EXCESSIVE BLEEDING
Y N F HIGH/LOW BLOOD PRESSURE
Y N F **DIABETES**
Y N SMOKER ☐ Past ☐ Present

Y N F OSTEOARTHRITIS
Y N F EPILEPSY
Y N F PACEMAKER
Y N F **STROKES**
Y N F **CANCER**
Y N F ULCERS
Y N F RUPTURES
Y N F COUGHING BLOOD

Y N F EATING DISORDER
Y N F ALCOHOLISM
Y N F DRUG ADDICTION
Y N F HIV POSITIVE
Y N F GALL BLADDER
Y N F **HEAD PROBLEMS**
Y N F DEPRESSION
Y N F TUMORS

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTORS TO KNOW? _____
_____

SYSTEM REVIEW ROS

IN THE LEFT-HAND COLUMN, PLEASE INDICATE WITH A (**C**) for **CURRENT CONDITIONS** or with a (**P**) for THE CONDITIONS YOU HAVE HAD **IN THE PAST.** IF NEITHER APPLY, MARK (**NA**), **DON'T LEAVE ANY BLANKS.**

Current Blood Pressure_____
Dizziness _____
Fainting_____
Insomnia_____
Headaches_____
Forgetful_____
Confusion_____
Fatigue_____
Ulcers_____
(other than glasses) Vision Disease _____
Ear/Hearing Problems_____
Difficulty Breathing_____
Heart Problems_____
Loss Of Bladder Control_____
Loss Of Bowel Control_____
Constipation_____
Diarrhea_____
Digestion Problems_____
Female Problems_____
Prostate Problems_____
Diabetes_____
(circle) Hands/Feet Cold_____
Hand Tremors_____
Loss Of Memory_____
Speech Difficulty_____
Anxiety_____
Seizures_____
Depression_____

For Medication List Below - - - - - - - - - -
PLEASE LIST *AND* ***IDENTIFY*** *WITH A CHECK (✓) ALL VITAMINS (**V**), PRESCRIPTION (**RX**) AND NON-PRESCRIPTIONS **(NON-RX)** MEDICATIONS YOU HAVE TAKEN OVER THE PAST YEAR AND / OR ARE CURRENTLY TAKING:*
CIRCLE WHO PRESCRIBED
***D** - DOCTOR or **S** - SELF*

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DR. REVIEWED	SYSTEMS	NEGATIVE (if box ✓ed)	SYMPTOMS
_____	GENERAL	☐	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity
_____	SKIN	☐	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
_____	HEAD	☐	Trauma, headaches, dizziness, light headedness
_____	EYES	☐	Change in acuity of vision, use of corrective lenses, loss of vision, diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____	EARS	☐	Changes in hearing, deafness, tinnitus, discharge, pain, vertigo, otitis
_____	NOSE	☐	Rhinorrhea, epistaxis, allergies, airway obstruction
_____	MOUTH & THROAT	☐	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain gum bleeding, soreness, swelling, enlarged glands, sore throat strep
_____	NECK	☐	Stiffness, lumps/swelling/masses, pain
_____	LUNGS	☐	Cough (productive/nonproductive), hemoptysis dyspnea, pain with respiration, wheezing, night sweats
_____	CARDIAC	☐	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____	VASCULAR	☐	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____	BREASTS	☐	Self-examination frequency/results, pain, nipple discharge, lumps/ masses, skin dimpling
_____	GASTRO/ INTESTINAL	☐	Unusual diet, dysphagia, regurgitation, dyspepsia, nausea, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling
_____	GENITO/ URINARY	☐	Polyuria, nocturia, oligun, dysuria, urgency, incontinence, urine color changes, hematuria, sexually transmitted diseases, syspareunia, scrotal mass (male), hernia
_____	ENDOCRINE	☐	Poldipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsutism, menstruation history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
_____	HEMATOPOLETIC	☐	Anemia, abdominal bleeding, lymph node enlargement
_____	MUSCULOSKELETAL	☐	Bone/joint pain, swelling, joint deformity, trauma, restricted range of motion weakness, atrophy
_____	NEUROLOGICAL	☐	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
_____	PSYCHOLOGICAL	☐	Mood swings, depression, anxiety, phobias

☐ ADDENDUM

SEE SYMPTOMS AREA or EXAM CARD FOR UNCHECKED BOXES

MEDICATION LIST

NAMES OF MEDICATION or VITAMINS	V	RX STRENGTH	NON-RX	DATE STARTED	DATE STOPPED	WHO? D / S
						D S
						D S
						D S
						D S
						D S
						D S

** FEMALES ONLY **

ARE YOUR PREGNANT?

☐ **YES** ☐ **NO**

WHAT WAS THE FIRST DAY OF YOUR LAST MENSTRUAL CYCLE?

_____

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TREATMENT PLANNING

The treatment plan for therapeutically necessary care has been divided into four phases, each having distinct objectives that allow for passive and active benefits. Efforts to reduce soft tissue and joint stress will be made to diminish inflammation and swelling, over a short term of reduced mobility to limit the joint loading effects of gravity. Passive forms of treatment/care, including manual and palliative procedures will be used with deference to type of mechanical lesion present. When pain and discomfort have abated, the area can be remobilized with low speed and minimal load exercise directed at improving flexibility without incurring mechanical stress. As the range of pain free motion improves, a gradual increase in exertion will be introduced. Lastly, when a maximal range of motion is achieved, a rehabilitation program to improve strength and endurance will be addressed.

The recommended course for care outlines diagnostics and therapeutic procedures to be preformed, goals and plans for patient education, nutritional guidance and /or counseling.

The treatment plan identifies imaging, and other diagnostics ordered, for the purpose of reducing the uncertainty surrounding management questions and/or confirming and contributing to the patient's clinical picture. Therapeutic procedures and adjuncts are listed with rationale to address (four) 4 stages of healing throughout each phase of care. Applications were selected for their effectiveness in expeditiously delivering the expectation of outcome. The care protocol, carefully aligned with current standards, requires treating the supporting structures as well as the injured are **(1990 Rand Consensus).** The program design addresses dissuading pain related behavior, education on body biomechanics, and training for flexibility, with stability, strength, coordination and endurance.

The initial plan considers all active problems and is an economically sensitive, efficacious approach to achieving short, as well as long term goals. (See page on "Care Management")1

Re-evaluation examinations will follow an appropriate period of treatment to determine if the current plan is working, rate progress relative to expectations, and assess the need for further care.

COMPLICATING FACTORS:_____ **NEUROGENIC EFFECTS**:_____

☐ **TRANSITIONAL SEGMENT** ☐ **TO EXTREMITY** **UPPER** **R** **L**

LOWER **R** **L**

ADDITIONAL CONSIDERATIONS: ☐ DEGENERATIVE PROCESSES ☐ ENVIRONMENTAL ☐ FUNCTIONAL DISABILITIES

☐ **BERLOTTI'S SYNDROME** ☐ OTHER _____

These factors said to exist may impede normal healing response time and/or delay recovery and as such should be taken into consideration when Determining a reasonable TX frequency spectrum for this patient.

THE PATIENT PROVIDED DATA AND INTIAL:
☒ SIGNS, SYMPTOMS, AND OBSERVATIONS ☐EVALUATION OF HISTORICAL DATA ☒ CLINICAL FINDINGS
INDICATE:
☐ FURTHER TESTING ☐ AN INCREASED LEVEL OF EXAMINATION ☐ IMAGING STUDIES ☐ LABORATORY TESTS
WOULD BE:
☒ DIAGNOSTICALLY ☒THERAPEUTICALLY ☒ PROGNOSTICALLY
EFFICACIOUS TO: ☒ IDENTIFY ☒ CONFIRM ☒ MONITOR ☒ ACCUIRE ☒ MANAGE ☒ EVALUATE
☒ PATIENT CONDITIONS ☐ PROGRESSIVE PATHOLOGY ☒CONTRAINDICATIONS ☒ POSTURAL/BIOMECHANICAL DATA

DATE	REFERRAL	

I hereby authorize the release of any information required. I, the patient, do hereby direct the health insurance carrier to issue payment on my behalf directly to the medical provider. I am financially responsible for non-covered services.

X_____ _____

Patient Signature **Date**

After explaining the potential risks as well as the benefits of the procedures to be performed, the patient has conveyed their understanding of all information and findings which were reported to them, and have given their consent to:

☒ IMAGING ☐ LAB ☒ TX TYPE CARE PLAN OUTLINED ☒ DIAGNOSTIC TESTS ORDERS ☐ MY MINOR CHILD

PATIENT'S SIGNATURE **X** **DOCTOR'S SIGNATURE**