Name:_____ **Application For Care**

1. Please describe the health problem, for which you are seeking care: _____

2. Were your symptoms: □ Were initiated by an injury □ Occurred gradually □ Occurred Suddenly □ Not initiated by injury

3. Have you ever had these symptoms before this episode? □ Y □ N, if yes, how many times in the past have you felt them. (That lasted at least one day, but went away completely) □ 1-5 times □ 6-10 times □ >10 times

4. Have your symptoms: □ Improved □ Worsen gradually □ Worsen quickly □ Stayed the same

5. Mark areas on the diagram at the right where you feel discomfort/symptoms:

6. When was the first time you felt these symptoms? _____

7. Are your symptoms worse in the: □ Morning □ Afternoon □ Night □ sleeping

8. Are your symptoms: □ <25% of the time □ 25%-50% □ 50% -90% □ 100%

9. Describe pain/sensations in the affected body parts and when it started (burning, tingling, numbness, pins & needles, sharp achy dull achy dull, etc.)

Head_____ Neck _____ Shoulder _____ Back _____ Groin _____ Arms _____
Hands _____ Leg(s) _____ Foot/Feet _____ Other _____

10. Please mark the scale to show how bad your discomfort has been recently. Please mark more than one area, and rate each pain, if you have more than one symptom.

No Discomfort 1 2 3 4 5 6 7 8 9 10 Worst possible discomfort

11. Describe what makes your symptoms worse: _____

12. Describe what makes your symptoms better: _____

13. Have you had treatment for this condition before? □ Y □ N, if yes, please state when you were treated, the name of the practitioner, and the results attained. _____

14. Do you have any recent x-rays (within the last 12 months) □ Y □ N

15. Do you exercise regularly? Please describe _____

16. Do you smoke? □ Y □ N, if yes, how much _____ drink alcohol? □ Y □ N, If yes, how much and how often? _____

17. Do you sleep poorly at night? □ Y □ N 2. Do you sleep on your stomach? □ Y □ N

18. Is your pain constant and significantly worse at night? □ Y □ N

Patient Goals: Please write down what you hope to achieve by becoming one of our patients. We have listed a few common ones

□ Get out of pain □ Work out with no pain □ Increase my range of motion □ Perform better in sports

Please list any other goals that are not listed above _____

Women Only

Are you or could you be pregnant? □ Y □ N 2. Are you still having menstrual periods? □ Y □ N, if yes, when was the first day of you last menstrual period? _____

Family Health History

1. Do you have any relatives with similar problems? □ Y □ N If yes explain: _____
2. Is there family history of: □ Cancer □ Diabetes □ Stroke □ High Blood Pressure □ Other If yes, please explain: _____

Past History

Please write in the year/years in which you had any of the following **and** mark **X** if you currently have any:

□ Anemia	□ Diabetes	□ Heart attack/Disease	□ Mumps	□ Gout
□ Angina	□ Digestive disorder	□ Heartburn	□ Pleurisy	□ Mutlipe sclerosis
□ Appendicitis	□ Dizziness/Fainting	□ Hepatitis	□ Pneumonia	□ Sinus problems
□ Arteriosclerosis	□ Double vision	□ High blood pressure	□ Polio	□ Stoke
□ Arthritis	□ Sexual abuse	□ HIV infection/positive	□ Poor circulation	□ Thyroid problem
□ Asthma	□ Depression	□ Kidney stones/disease	□ Prostate hypertrophy	□ TMJ
□ Back/Neck surgery	□ Ear infections	□ Low blood pressure	□ Psoriasis	□ Tuberculosis
□ Bowel disease	□ Eczema	□ Lupus	□ Raynauds	□ Ulcer
□ Cancer	□ Epilepsy	□ Measles	□ Rehumatic fever	□ Venereal disease
□ Carpal tunnel	□ Fatigue	□ Migraine headaches	□ Scarlet fever	□ Drug/Alcohol Dependence
□ Chicken pox				

_____ Other Condition Not Listed _____

_____ Allergies (Please check any of the following items that you have allergic reactions to)

□ Soap □ Lotions □ Vinyl □ Oils □ Detergent □ Fragrances □ Latex □ Other _____

1. Have you had any surgeries or been hospitalized? □ Y □ N, if yes, please explain:_____
2. Please list ALL medications/vitamins/supplements you are currently taking or those, which you have discontinued, but took for a long period of time: _____

Please only fill out the following sections that apply to you

NECK REGION

1. Mark any of the following activities that increase you neck pain: ____ reading ____ standing ____ turning head ____ stress ____ other _____
2. Do you get dizzy when you look up or twist you head? ____ Y ____ N
3. If your neck pain is a result of an old injury, did you hear any popping/snapping/tearing? Circle the correct answer.
4. Have you been diagnosed as having disc degeneration or bulging/herniation in your neck in the past? ____ Y ____ N
5. Do you have headaches that you think may be related to your neck pain? ____ Y ____ N
6. Does coughing, sneezing, or bowel movements increase your pain? ____ Y ____ N

ARM, HAND, AND FINGER REGION:

1. Do you have pain, numbness, swelling, or tingling in you shoulder / upper arm / forearm hand? Please circle which and indicate which side. Left, Right or Both
2. Do you feel weakness in your grip strength or have you noticed you are dropping objects recently? ____ Y ____ N
3. Do your arm symptoms change when you lift your arms over your head? ____ Improve _____ Worsen _____ Stay the Same

MID BACK AND CHEST WALL REGION

1. Does your mid back pain intensify when you take a deep breath? ____ Y ____ N
2. Does your mid back pain intensify when you twist your torso? ____ Y ____ N
3. Do you have a tight feeling in your chest or down your left arm? ____ Y ____ N
4. Do you have shortness of breath? ____ Y ____ N

LOW BACK, HIP AND LEG/FOOT REGION:

Check all the following movements that intensify low back pain or leg symptoms and write where you feel the pain with these actions?

□ Sitting □ Standing □ Bending Forward □ Bending Backward □ Standing Up □ Lying on Your Back □ Walking

Check any locations of any current leg pain, numbness or tingling:

□Hip □ Groin Area □ Buttock □ Back of Thigh □ Front of Thigh □ Knee □ Lower Leg □ Ankle □ Foot/Toes

1. If your back pain is a result of an injury, did you hear any popping/snapping/tearing? Circle the correct answer.
2. When you cough, sneeze, or bear down to have a bowel movement, does you low back/leg pain get worse? ____ Y____ N
3. Is your low back pain relieved by any type of postural change? ____ Y ____ N If yes, circle all that apply: sitting straight, bending forward, bending backward, bending left, or bending right.
4. Have you ever been diagnosed as having a herniated/bulging disc or stenosis in your low back? ____ Y ____ N
5. Have your anal-rectal region been completely numb recently or have you had any significant changes in your bowel/bladder habits? ____ Y ____ N
6. Have you had any difficulty with walking? ____ Y ____ N

***I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information could be detrimental to my health.**

_____ _____

DATE **PATIENTS'S SIGNATURE**