



Patient Application Form

Welcome to our office! We specialize in assisting our patients to achieve their highest level of health through our spinal corrective programs along with other lifestyle and holistic recommendations. Our approach is very unique and advanced from other rehabilitation programs. This allows our patients to achieve far superior results compared to other systems.

Please fill out the following information completely so the doctor can get a thorough understanding of your health status. Please feel free to ask any questions if you need assistance.
We look forward to serving you!

Patient Name: _____

Patient Signature: _____

Date: _____

Tell Us About Yourself

Name: _____ Age: _____ Gender: M F
Home Address: _____ Cell: () _____
City, State, Zip: _____ Home: () _____
Email Address: _____ Work: () _____
Employer: _____
Birth Date: _____ Social Security #: _____ Marital Status: S M D W
Spouse's Name: _____ Spouse's Employer: _____
Can we leave a message on your: Cell Home Office With Spouse
How were you referred to this office?: _____

Purpose Of This Visit

Main Health Concern: _____
Other Health Concerns: _____
Is this problem related to an auto accident/ work injury? Yes No If so, when: _____
Describe: _____
When did this condition begin? _____ Is it getting worse?: Yes No
Please describe the pain and it's location: _____
How Often Do You Notice It? _____
This condition is: Constant Comes and Goes Activity Related Dull Sharp Pain
This complaint interferes with: Work Sleep Hobbies Sitting Standing Bending Lifting
Is there anything that has relieved your symptoms? Yes No Describe: _____
Have you experienced this condition before? Yes No When? _____
Describe: _____
Who have you seen for this? _____ What did they recommend? _____
How did you respond? _____

Experience With Chiropractic

Have you seen a Chiropractor before? Yes No Who? _____ When? _____

Reason for visit: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No
(If x-rays were taken at a previous doctor's office, please bring them to your appointment if possible.)

Did they instruct you on postural exercises? Yes No

Health and Lifestyle

Do you exercise? Yes No How often? ____x per week Other: _____

Percent of Time: Sitting: _____ Standing: _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much/ week? _____

Do you drink coffee? Yes No How many cups/ day? _____

Are you on a special diet? _____

List all supplements: _____

List all medications: _____

Cervical Spine

Postural distortions from subluxations in your neck, as in Forward Head Syndrome, irritate nerves and other organs and can cause the following.

Check All That Apply: (A) Past (B) Present (C) Recurring

A B C

Neck Pain

Pain in your shoulders/
arms/hands

Numbness/tingling in
arms/hands

Hearing disturbances

Weakness in grip

A B C

Dizziness

Visual disturbances

Coldness in hands

Thyroid conditions

Sinusitis

A B C

Headaches

Recurrent colds/ flu

Allergies/ Hay fever

Low energy/ fatigue

Explain: _____

Thoracic Spine (Upper Back)

Postural distortions from subluxations in the upper back can irritate the nerves to the heart and lungs and can cause the following

Check All That Apply: (A) Past (B) Present (C) Recurring

A B C

Heart Palpitations

Heart Murmurs

Increased Heart Rate

Decreased Heart Rate

Heart Attacks/ Angina

A B C

Recurrent Lung Infections/Bronchitis

Asthma/ Wheezing

Shortness of breath

Pain on deep inspiration/ expiration

Thoracic Spine (Mid Back)

Postural distortions from subluxations in the mid back can irritate the nerves into your ribs, chest, upper digestive tract and organs and can cause the following:

Check All That Apply: (A) Past (B) Present (C) Recurring

A B C

Mid Back Pain

Chest Pain

Indigestion/ Heartburn

Reflux

A B C

Nausea

Ulcers/ Gastritis

Hypoglycemia

Tired after eating or irritable when you haven't eaten for awhile

Lumbar Spine (Low Back)

Postural distortions from subluxations in the low back can irritate nerves into your legs, feet and pelvic organs and cause the following:

Check All That Apply: (A) Past (B) Present (C) Recurring

A B C

Pain Into Your Hips/Legs/Feet

Bladder Infections

Coldness In Your Legs/Feet

Sexual Dysfunction

Constipation/ Diarrhea

Low Back Pain

A B C

Weakness/ Injuries In Your Hips/Knees/Ankles

Numbness/Tingling In Your Legs/Feet

Frequent/Difficulty Urinating

Muscle Cramps In Your Legs/ Feet

Menstrual Irregularities/ Cramps (females)

Neck Disability Index

Please Read carefully! This questionnaire has been designed to enable us to understand how your **neck pain** has affected your ability to manage everyday life. Please answer every section, and mark the box that most accurately describes your problem right now.

Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment
- C. The pain is moderate at the moment
- D. The pain is fairly severe at the moment
- E. The pain is very severe at the moment
- F. The pain is the worst imaginable at the moment

Personal Care (washing, dressing, etc.)

- A. I can look after myself without causing extra pain
- B. I can look after myself normally but it causes extra pain
- C. It is painful to look after myself and I am slow and careful
- D. I need some help but manage most of my personal care
- E. I need help everyday in most aspects of self care
- F. I do not get dressed, wash with difficulty and stay in bed

Lifting

- A. I can lift heavy weights without extra pain
- B. I can lift heavy weights but it gives extra pain
- C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned. E.g. on a table
- D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights
- F. I cannot lift or carry anything at all

Reading

- A. I can read as much as I want with no pain to my neck
- B. I can read as much as I want with slight pain in my neck
- C. I can read as much as I want with moderate pain in my neck
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I can hardly read at all because of severe pain in my neck
- F. I cannot read at all because of severe pain in my neck

Headaches

- A. I have no headaches at all
- B. I have slight headaches which come infrequently
- C. I have moderate headaches which come infrequently
- D. I have moderate headaches which come frequently
- E. I have severe headaches which come frequently
- F. I have headaches almost all the time

Concentration

- A. I can concentrate fully when I want to with no difficulty
- B. I can concentrate fully when I want to with slight difficulty
- C. I have a fair degree of difficulty in concentrating
- D. I have a great deal of difficulty in concentrating
- E. I cannot concentrate at all

Work

- A. I can do as much work as I want to
- B. I can only do my usual work, but no more
- C. I can do most of my usual work, but no more
- D. I cannot do my usual work
- E. I can hardly do any work at all
- F. I cannot do any work at all

Driving

- A. I can drive without any neck pain
- B. I can drive as long as I want with slight pain in my neck
- C. I can drive as long as I want with moderate pain in my neck
- D. I cannot drive as long as I want because of moderate pain in my neck
- E. I can hardly drive at all because of severe pain in my neck
- F. I cannot drive my car at all

Sleeping

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hr sleepless)
- C. My sleep is mildly disturbed (1-2 hrs sleepless)
- D. My sleep is moderately disturbed (2-3 hrs sleepless)
- E. My sleep is greatly disturbed (3-5 hrs sleepless)
- F. My sleep is completely disturbed (5-7 hrs sleepless)

Recreation

- A. I am able to engage in all my recreation activities with no neck pain at all
- B. I am able to engage in all my recreation activities with some pain in my neck
- C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- D. I can hardly do any recreation activities because of pain in my neck
- E. I cannot do any recreation activities at all

Other Comments:

Patient Name: _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Back Disability Index

Please Read carefully! This questionnaire has been designed to enable us to understand how your **back pain** has affected your ability to manage everyday life. Please answer every section, and mark the box that most accurately describes your problem right now.

Pain Intensity

- A. The pain comes and goes and is very mild
- B. The pain is mild and does not vary much
- C. The pain comes and goes and is moderate
- D. The pain is moderate and does not vary much
- E. The pain comes and goes and is severe
- F. The pain is severe and does not vary much

Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it
- E. Because of the pain, I am unable to do some washing and dressing without help
- F. Because of the pain, I am unable to do any washing or dressing without help

Lifting

- A. I can lift heavy weights without extra pain
- B. I can lift heavy weights but it gives me extra pain
- C. Pain prevents me from lifting heavy weights off the floor
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- F. I can only lift very light weights, at the most

Walking

- A. Pain does not prevent me from walking any distance
- B. Pain prevents me from walking more than 1 mile
- C. Pain prevents me from walking more than 1/2 mile
- D. Pain prevents me from walking more than 1/4 mile
- E. I can only walk using a stick or crutches
- F. I am in bed most of the time and have to crawl to the toilet

Sitting

- A. I can sit in any chair as long as I like without pain
- B. I can only sit in my favorite chair as long as I like
- C. Pain prevents me from sitting more than 1 hour
- D. Pain prevents me from sitting more than 1/2 hour
- E. Pain prevents me from sitting more than 10 minutes
- F. Pain prevents me from sitting at all

Standing

- A. I can stand as long as I want without pain
- B. I have some pain while standing but it does not increase with time
- C. I cannot stand for longer than 1 hour without increasing pain
- D. I cannot stand for longer than 1/2 hour without increasing pain
- E. I cannot stand for longer than 10 minutes without increasing pain
- F. Pain prevents me from standing at all

Sleeping

- A. I get no pain in bed
- B. I get pain in bed, but it doesn't prevent me from sleeping well
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter
- D. Because of pain, my normal night's sleep is reduced by less than one-half
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters
- F. Pain prevents me from sleeping at all

Social Life

- A. My social life is normal and gives me no pain
- B. My social life is normal, but increases the degree of my pain
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests- eg dancing
- D. Pain has restricted my social life and I do not go out very often
- E. Pain has restricted my social life to my home
- F. I have hardly any social life because of the pain

Traveling

- A. I get no pain while traveling
- B. I get some pain while traveling but none of my usual forms of travel make it any worse
- C. I get extra pain while traveling but it does not compel me to seek alternate forms of travel
- D. I get extra pain while traveling which compels me to seek alternative forms of travel
- E. Pain restricts all forms of travel
- F. Pain prevents all forms of travel except that done laying down

Changing Degree of Pain

- A. My pain is rapidly getting better
- B. My pain fluctuates, but overall is definitely getting better
- C. My pain seems to be getting better, but improvement is slow at present
- D. My pain is neither getting better nor worse
- E. My pain is gradually worsening
- F. My pain is rapidly worsening

Patient Name: _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____