

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State _____ Zip: _____ E-Mail: _____

Home #: _____ Work #: _____ Cell #: _____

Marital Status: M W D S (circle one)

Birth Date: ____/____/____ Age: _____

Who may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____

Chiropractic techniques you've had success with: _____

Last Chiropractic Visit: _____

General practitioner: _____ City: _____

Place of Employment: _____ Phone number: _____

Occupation: _____

Employer's address: _____

Spouse's Name: _____

Spouse's employer: _____

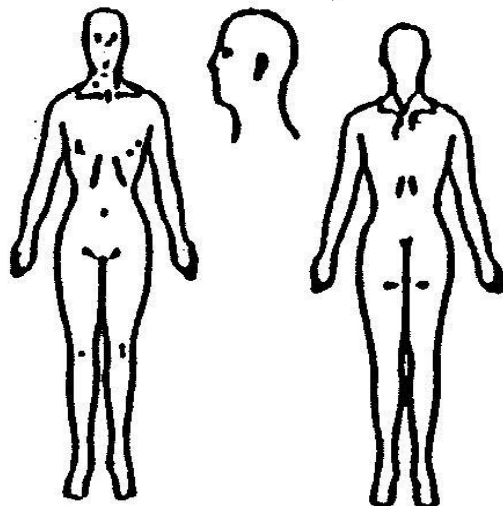
Children's names & ages: _____

Favorite hobbies or interests: _____

Method of payment for first visit:

____ Cash ____ Check ____ Credit Card

Mark area(s) of Health Concerns



Health reasons for consulting our office:

1. _____ 3. _____
2. _____ 4. _____

Have you had same or similar problem(s) before? Yes _____ No _____

How long? _____ Please explain: _____

Father/Mother/Brother/Sister/Children with similar problems?

Is this the result of an auto or work injury? _____ If so, when? _____

Other doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes ___ No ___

What have you heard about chiropractic care?

Do you know what a *subluxation* is? If yes, please describe

What daily rituals for spinal health do you presently practice?

Have you ever been diagnosed with cancer? Yes _____ No _____

If so, what type? _____

Do you have health insurance? Yes _____ No _____ Name of company: _____



The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ Date: ____/____/____

Name: _____ DOB: _____

Health History:

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern(s).

Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/> No <input type="checkbox"/>	Immune System Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Infertility	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Menstrual Cramps/Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mood Swings	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neck Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory/Vascular Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Numbness/Tingling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea/Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Digestive Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Conditions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep Challenges	Yes <input type="checkbox"/> No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Urinary Difficulty	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heartburn/Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vertigo	Yes <input type="checkbox"/> No <input type="checkbox"/>

Other _____

Stress History:

Please indicate whether you have EVER experienced stress in any of the following areas.

I. Childhood

Repeated/Prolonged Antibiotic Use	Yes <input type="checkbox"/> No <input type="checkbox"/>	Inhaler Use	Yes <input type="checkbox"/> No <input type="checkbox"/>
Car Accident	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prescription Medications	Yes <input type="checkbox"/> No <input type="checkbox"/>
Childhood Illness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fall/Jump from a height < 3 FT	Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaccination	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fall/Jump from a height > 3 FT	Yes <input type="checkbox"/> No <input type="checkbox"/>	Youth Sports	Yes <input type="checkbox"/> No <input type="checkbox"/>
Head Trauma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Traumas (physical or emotional):	_____

II. Adulthood

Over the counter medications	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prescription Medications	Yes <input type="checkbox"/> No <input type="checkbox"/>
Repeated/Prolonged Antibiotics	Yes <input type="checkbox"/> No <input type="checkbox"/>	Inhaler Use	Yes <input type="checkbox"/> No <input type="checkbox"/>
Car Accident	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tobacco Use	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug Use/Abuse	Yes <input type="checkbox"/> No <input type="checkbox"/>	<u>If Yes Circle One:</u> _____ <i>Everyday, Occasional, Former</i>	
Head Trauma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fall/Jump from a height	Yes <input type="checkbox"/> No <input type="checkbox"/>
Home Environment Stress	Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Sports	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Traumas (physical or emotions):	_____	Workplace Stress	Yes <input type="checkbox"/> No <input type="checkbox"/>

Lifestyle Information:

Do you exercise? Yes No If yes, how much & how often? _____
Do you consume alcohol? Yes No If yes, how much & how often? _____
Do you drink soft drinks? Yes No If yes, how much? _____
Do you drink water? Yes No If yes, how much? _____
Do you drink coffee? Yes No If yes, how much? _____

How would you rate your nutritional habits? **Great** **Good** **Fair** **Poor**

Do you take any vitamins/supplements? Yes No If yes, what kind? _____

How many hours of sleep do you usually get? _____ hours

Is the quality of sleep: **Great** **Good** **Fair** **Poor**

Stress Level (personal): **Low** **Medium** **High**

Stress Level (work): **Low** **Medium** **High**

What do you do to relieve or handle your stress?

Medications:

Please list **ALL** medications, **DOSAGE** and **FREQUENCY** information.

- Pain Medication (over the counter/prescription) _____
- Birth Control _____
- Heart Medication _____
- Cholesterol Medication _____
- Antidepressant/ Anti-Anxiety Medication _____
- Recreation Drugs _____
- Anti-Inflammatory Medication _____
- Muscle Relaxers _____
- Aspirin _____
- Blood Pressure Medication _____
- Diabetes Medication _____
- Other _____
- Medication Allergies _____

Signature of Applicant : _____ **Date:** _____
(Guardian or Personal Representative)

SYMPTOM DIAGRAM

Name _____ Number _____ Date _____

Please be sure to fill this form out extremely accurately. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.

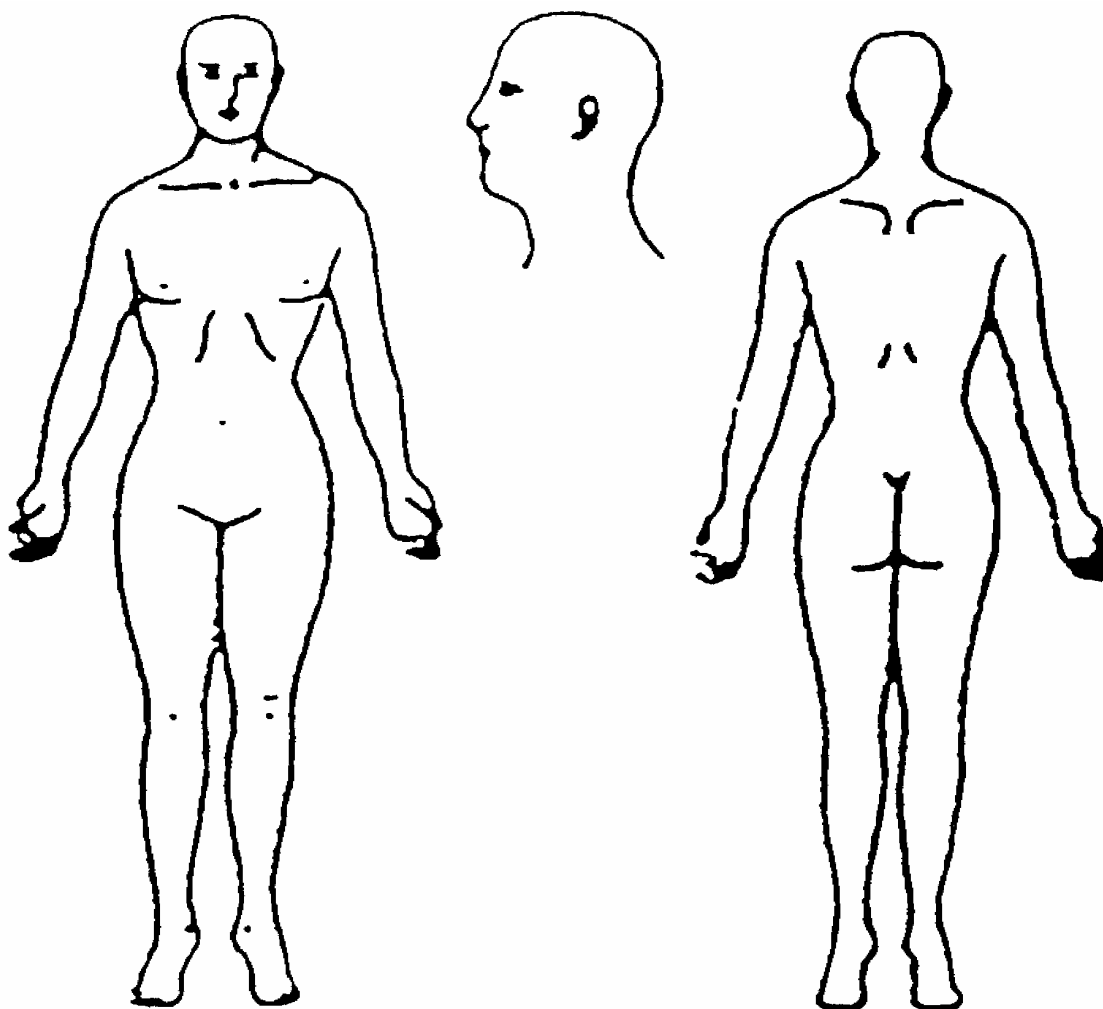
Aches $\wedge\wedge\wedge$

Numbness oooo

Pins/Needles ●●●●

Burning xxxx

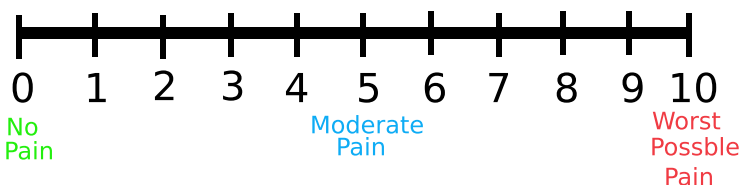
Stabbing ///



VAS

Please rate your pain level:

0-10 Numeric Pain Rating Scale



MY PAIN IS:

Acute (new)
 Chronic (old)

Daily
 Weekly
 Monthly

Other _____

Neck Disability Index

Name: _____

Date: _____

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you.

Section 1: Pain Intensity

- I have no pain at this moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (washing, dressing, etc.)

- I can look after myself normally w/out causing extra pain
- I can look after myself normally, but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, I was with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights, but it gives extra pain
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Reading

- I can read as much as I want to with no pain in my neck
- I can read as much as I want with slight pain
- I can read as much as I want with moderate pain
- I can't read as much as I want because of moderate pain
- I can hardly read at all because of severe pain
- I cannot read at all

Section 5: Headaches

- I have no headaches at all
- I have slight headaches, which come infrequently
- I have moderate headaches, which come infrequently
- I have moderate headaches, which come frequently
- I have severe headaches, which come frequently
- I have headaches almost all of the time

Section 6: Concentration

- I can concentrate fully when I want to with no difficulty
- I can concentrate fully when I want to with slight difficulty
- I have a fair degree of difficulty in concentrating when I want to
- I have a lot of difficulty in concentrating when I want to
- I have a great deal of difficulty in concentrating when I want to
- I cannot concentrate at all

Section 7: Work

- I can do as much work as I want to
- I can only do my usual work, but no more
- I can do most of my usual work, but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8: Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight pain
- I can drive my car as long as I want with moderate pain
- I can't drive my car as long as I want because of moderate pain
- I can hardly drive at all because of severe pain
- I can't drive my car at all

Section 9: Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (<1 hr sleepless)
- My sleep is mildly disturbed (1-2 hrs sleepless)
- My sleep is moderately disturbed (2-3 hrs sleepless)
- My sleep is greatly disturbed (3-5 hrs sleepless)
- My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

- I am able to engage in all of my recreation activities with no neck pain at all
- I am able to engage in all my recreation activities with some pain in my neck
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
- I can hardly do any recreation activities because of pain in my neck
- I can't do any recreation activities at all

Oswestry Low Back Pain Index

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday activities. Please mark ONE LETTER in each section that applies to you. Although you may consider that two statements may apply to you, please mark the one that MOST CLOSELY describes your current condition.

Pain Intensity

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

Standing

- A. Can stand for an unlimited amount of time w/o pain
- B. Some pain standing doesn't increase with time.
- C. Cannot stand for more than 1 hour.
- D. Cannot stand for more than 1/2 hour.
- E. Cannot stand for more than 10 minutes.
- F. Cannot stand at all.

Personal Care

- A. Does not change habits to avoid pain.
- B. Does not change habits but have some pain.
- C. Does not change habits but increases the pain.
- D. Changes habits due to pain.
- E. Unable to do personal care without some help.
- F. Unable to wash or dress without help.

Sleeping

- A. No pain in bed.
- B. Gets pain in bed, but sleeps well.
- C. Normal night's sleep reduced by 1/4.
- D. Normal night's sleep reduced by 1/2.
- E. Normal night's sleep reduced by 3/4.
- F. Cannot sleep at all due to pain.

Lifting

- A. Lifts heavy weights with no pain.
- B. Lifts heavy weights with pain.
- C. Cannot lift heavy weights off the floor.
- D. Can lift heavy weights from a table.
- E. Can lift light weights from table.
- F. Can lift only very light weights.

Traveling

- A. Travel without pain.
- B. Travel causes some pain, but not made worse.
- C. Causes extra pain, no change in form.
- D. Causes pain, uses alternative travel.
- E. Pain restricts all form of travel.
- F. Pain restricts except lying down.

Walking

- A. Pain does not prevent walking.
- B. Cannot walk more than 1 mile.
- C. Cannot walk more than 1/2 mile.
- D. Cannot walk more than 1/4 mile.
- E. Can walk only with cane or crutches.
- F. Bedridden and must crawl to toilet.

Social life

- A. Normal and causes no pain.
- B. Normal but causes extra pain.
- C. Limits more energetic interests. (Dancing etc.)
- D. Pain limits me, do not go out as often.
- E. Pain restricts my social life to home.
- F. Pain restricts all social life.

Sitting

- A. Can sit in any chair as long as desired.
- B. Can sit only in favorite chair as long as desired.
- C. Can sit no more than 1 hour.
- D. Can sit no more than 1/2 hour.
- E. Can sit no more than 10 minutes.
- F. Cannot sit at all due to pain.

Changing Degree of Pain

- A. Pain is rapidly improving.
- B. Pain fluctuates but is improving.
- C. Improvement is slow.
- D. Pain level is unchanged.
- E. Pain is gradually worsening.
- A. F. Pain is rapidly worsening.

Patient Name: _____ Date: _____

Signature: _____

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

- Point Scale
- 0 - Never or almost never have the symptom
 - 1 - Occasionally have it, effect is not severe
 - 2 - Occasionally have it, effect is severe
 - 3 - Frequently have it, effect is not severe
 - 4 - Frequently have it, effect is severe

Head

- _____ Headaches
- _____ Faintness
- _____ Dizziness
- _____ Insomnia

Total _____

Eyes

- _____ Watery or Itchy Eyes
- _____ Swollen, Reddened or Sticky Eyelids
- _____ Bags or Dark Circles Under Eyes
- _____ Blurred or Tunnel Vision
(does not include near or far-sighted)

Total _____

Ears

- _____ Itchy Ears
- _____ Earaches, Ear Infections
- _____ Drainage from Ear
- _____ Ringing in Ears, Hearing Loss

Total _____

Nose

- _____ Stuffy Nose
- _____ Sinus Problems
- _____ Hay Fever
- _____ Sneezing Attacks
- _____ Excessive Mucus Formation

Total _____

**Mouth/
Throat**

- _____ Chronic Coughing
- _____ Gagging, Frequent Need to Clear Throat
- _____ Sore Throat, Hoarseness, Loss of Voice
- _____ Swollen or Discolored Tongue, Gums, or Lips
- _____ Canker Sores

Total _____

Skin

- _____ Acne
- _____ Hives, Rashes, Dry Skin
- _____ Hair Loss
- _____ Flushing, Hot Flashes
- _____ Excessive Sweating

Total _____

Heart

- _____ Irregular or Skipped Heartbeat
- _____ Rapid or Pounding Heartbeat
- _____ Chest Pain

Total _____

The Wellness Score™

Lungs _____ Chest Congestion
 _____ Asthma, Bronchitis
 _____ Shortness of Breath
 _____ Difficulty Breathing
Total _____

Digestion _____ Nausea, Vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating Feeling
 _____ Belching, Passing Gas
 _____ Heartburn
 _____ Intestinal/Stomach Pain
Total _____

**Joints/
Muscles** _____ Pain or Aches in Joints
 _____ Arthritis
 _____ Stiffness or Limitation of Movement
 _____ Pain or Aches in Muscles
 _____ Feeling of Weakness or Tiredness
Total _____

Weight _____ Binge Eating/Drinking
 _____ Craving Certain Foods
 _____ Excessive Weight
 _____ Compulsive Eating
 _____ Water Retention
 _____ Underweight
Total _____

**Energy/
Activity** _____ Fatigue, Sluggishness
 _____ Apathy, Lethargy
 _____ Hyperactivity
 _____ Restlessness
Total _____

Mind _____ Poor Memory
 _____ Confusion, Poor Comprehension
 _____ Poor Concentration
 _____ Poor Physical Condition
 _____ Difficulty in Making Decisions
 _____ Stuttering or Stammering
 _____ Slurred Speech
 _____ Learning Disabilities
Total _____

Emotions _____ Mood Swings
 _____ Anxiety, Fear, Nervousness
 _____ Anger, Irritability, Aggressiveness
 _____ Depression
Total _____

Other _____ Frequent Illness
 _____ Frequent or Urgent Urination
 _____ Genital Itch or Discharge
Total _____

Grand Total _____

Health Satisfaction Score (HSS)

Name: _____ Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

[1 - Absolutely Disagree] [2] [3] [4] [5] [6] [7] [8] [9] [10 - Absolutely Agree]

Section 1 - Physical Health

1. I am a physically fit person and formally exercise on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I have a physically attractive body that I am proud to look at in the mirror.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I get at least 7 hours of sleep, 7 days at week
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I have gotten regular Chiropractic care within the past 5 years.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total _____

Section 2 - Emotional/Mental Health

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
8. Most of the time, I am truly happy and feel a sense of purpose in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
9. I have healthy relationships and a rich social network of friends and activities.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
10. I am organized, have time for myself, and can prioritize the important tasks in my life.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

11. I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
14. I do not smoke cigarettes.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
15. I drink water as my primary beverage and consume at least 30 ounces per day.
[1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 total _____

Grand total of all three sections: _____