Patient Application Survey

Name ______________________ Date ______________________

Age ________ Date of Birth ______________ ☐ Male ☐ Female SSN: ______________

Address: ______________________ Cell Phone ______________________

City ____________ State ______ Zip ________ Home Phone ______________________

Employed By ______________________ Work Phone ______________________

Insured By ____

Name of Spouse ______________________ E-mail Address ______________________

How did you hear about us? ____

PURPOSE OF THIS VISIT

Reason for this visit ____

Is this purpose related to an auto accident? ☐ Yes ☐ No

Describe ____

When did this condition begin/when did you first notice it? ______________________

Describe ____

What activities aggravate your symptoms? ____

Is there anything which has relieved your symptoms? ☐ Yes ☐ No

Describe ____

Have you experienced this condition before? ☐ Yes ☐ No

Describe ____

Who did you see for this? ____

What did they do? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No

Who? ____

When? ____

Reason for visits ____

How did you respond? ____

Did you know your posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor postural habits? ☐ Yes ☐ No

HEALTH LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? ____________________

What activities? ____________________

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? ____________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? ____________________

HEALTH CONDITIONS

CERVICAL SPINE (NECK):

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Coldness in Hands
- ☐ Thyroid Conditions
- ☐ SleepProblemss
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurrent Colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking
- ☐ Irritability

THORACIC SPINE (UPPER BACK)

- ☐ Heart Palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/Angina
- ☐ Recurrent lung infections/bronchitis
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

THORACIC SPINE (MID BACK):

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Tachycardia
- ☐ Indigestion/Heartburn
- ☐ Hypoglycemia
- ☐ Tired/irritable after eating or when you haven’t eaten for a while
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ WeightTrouble

LUMBAR SPINE (LOW BACK):

- ☐ Low Back Pain
- ☐ Pain into your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Weakness/injuries in your hips/ knees/ankles
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Constipation/Diarrhea
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction

IN CASE OF EMERGENCY CALL

Name ______________________ Relationship ______________________

Home Phone ______________________ Work Phone ______________________

Cell Phone ______________________

Relative not living with you ______________________ Phone ______________________

Past Health History:

Previous illnesses you've had in your life ______________________

Previous Injury or Trauma: ______________________

Have you ever broken any bones? Which? ______________________

Allergies: ______________________

Medication & Reason for taking ______________________

Surgeries:
Type of Surgery & Date ______________________

Family Health History:
Health problems of relatives ______________________

Deaths in immediate family:
Cause of parents or siblings death Age at death ______________________

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Wayne Johnson D.C./Johnson Chiropractic for services performed.

Patient's Signature
or Guardian ______________________ Date ______________

Please fill out the following for all of your sysmtpms as completely as possible

Symptom # 1 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

Symptom # 2 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

Symptom # 3 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

Symptom # 4 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

Symptom # 5 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

Symptom # 6 ______________________________

On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time: Pain Scale ________

What percentage of the time you are awake do you experience the above symptom at the above intensity

Percent of time __________

When did the symptom begin? ______________________________

Did the symptom begin ☐ Gradually ☐ Suddenly

How did the symptom begin? ______________________________

What makes the symptom worse? (check all that apply):

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other ______________________________

What makes the symptom better? (check all that apply):

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other ______________________________

Describe the quality of the symptom (check all that apply):

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other ______________________________

Does the symptom radiate to another part of your body ☐ Yes ☐ No

If yes, where does the symptom radiate? ______________________________

Is the symptom worse at certain times of the day or night? (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day