

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Cell or Home *We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you*

Date of Birth _____ Social Security _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ Phone Number _____

Your Occupation _____ Retired? Yes No

Emergency Contact _____

REVIEW OF SYMPTOMS

Please check all that apply

- Foot Pain, Hand Pain, Low Back Pain, Neck Pain, Foot Numbness, Hand Numbness, Diabetes, High Cholesterol, High Blood Pressure, Pacemaker/Defibrillator, Herniated Disc, Bulging Disc, Spinal Stenosis, Degenerative Disc, Vascular Problems, Leg Pain, Plantar Fasciitis, Morton's Neuroma, Cancer, Chemotherapy, Arthritis in Hands, Arthritis in Feet, Implanted Cord/Bladder Stimulator, Sciatica, Pinched Nerve, Poor Circulation, Joint Replacement, Foot Surgery, Poor wound healing, Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

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

List approximately how long you have noticed these problems:

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

Is there a certain time of day any of these problems are better or worse?

List the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams

Is your balance/walking ability affected? If yes, please describe:

What do you think is causing your problem?

Name of all doctors you have seen for these problems and treatment you received:

➔ **Have your symptoms:** Improved Worsened Stayed the same

List anything that makes your condition worse _____

List anything that makes your condition better _____

➔ **How would you describe the symptoms? Please check ALL that apply**

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Aching Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Hot Sensation | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Dead Feeling | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Heavy Feeling | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Electric Shocks |

➔ **Is this condition interfering with any of the following?**

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing |

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many cigarettes daily? _____

Do you drink? Yes No If yes, how many drinks per week? _____

Do you exercise regularly? Yes No If yes, please describe type & how often: _____

CURRENT PAIN LEVELS

➔ **How would you rate your pain in the last week?**

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

➔ **If you had to accept some level of pain after completion of treatment, what would be an acceptable level?**

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

PREVIOUS HEALTH HISTORY/HEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ Signature _____

Please give name, address, and office phone number of your primary care physician.

Name _____ Phone _____ Address _____

When were you last seen there?

May we send them updates on your treatment/condition? Yes No

List ALL allergies/sensitivities to medication, food, and other items here:

<i>Item you react to:</i>	<i>Reaction:</i>
_____	_____
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

<i>Name</i>	<i>Dose (mg or IU)</i>	<i>Times Daily</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____