CONSULT

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

Date:_____

PERSONAL INFORMATION

Name _____ Nickname _____ Age _____ Email _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Cell Phone _____ Home Phone _____

Prior Occupation _____ Present Occupation _____ Spouse's Name _____

Emergency Contact Name _____ Relation _____Phone Number _____

Review of Systems (Please Check & Circle ALL That Apply)

Pain In:
___ Back/ Neck
___ Shoulder Rt/Lt/Both
___ Elbow Rt/Lt/Both
___ Wrist Rt/Lt/Both
___ Hand Rt/Lt/Both
___ Hip Rt/Lt/Both
___ Knee Rt/Lt/Both
___ Ankle Rt/Lt/Both
___ Foot Rt/Lt/Both

Arthritis In:
___ Back/ Neck
___ Shoulder Rt/Lt/Both
___ Elbow Rt/Lt/Both
___ Wrist Rt/Lt/Both
___ Hand Rt/Lt/Both
___ Hip Rt/Lt/Both
___ Knee Rt/Lt/Both
___ Ankle Rt/Lt/Both
___ Foot Rt/Lt/Both

Surgery In:
_____
_____
_____
_____

Joint Replacement:
_____
_____
_____
_____

___ Implanted Cord
___ Bladder Stimulator
___ Sciatica
___ Pinched Nerve
___ Poor Circulation
___ Vascular Problems
___ Cancer
___ Chemotherapy
Other_____
_____

___ High Cholesterol
___ High Blood Pressure
___ Pacemaker/Defibrillator
___ Herniated/ Bulging Disc
___ Spinal Stenosis
___ Degenerative Disc
___ Diabetes Type 1 / 2
___ Numbness/Tingling
___ Plantar Fasciitis Other
_____

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected & How Long Have you had them.

1. _____ _____ 2. _____ _____

3. _____ _____ 4. _____ _____

Is there a certain time of day any of these problems are better or worst _____

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

What do you think is causing your problem? _____

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

_____

Have your symptoms: ____ Improved ____ Stayed the Same ____ Gotten Worst

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

___ Aching ___ Numbness ___ Hot Sensation ___ Cramping ___ Stabbing Pain ___ Electric

___ Tingling ___ Throbbing Pain ___ Swelling ___ Sharp Pain ___ Pins & Needles Shocks

___ Dead Feeling ___ Burning ___ Tiredness ___ Heavy Feeling ___ Cold Hands & Feet

Circle the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta Alieve Motrin PhysicalTherapy Pain Medications Tylenol Ibuprofen Chiropractic MassageTherapy Steroid Injections Creams Other _____ _____ _____ _____

Is this condition interfering with any of the following?

___ Sleep ___ Work ___ Daily Activities ___ Recreational Activities ___ Walking ___ Standing ___ Sitting

CONSULT

SOCIAL HISTORY

Do you: Smoke? Y N ____/Day/Week Drink? Y N ___/Day/Week Exercise? Y N ___/Day/Week

CURRENT PAIN LEVELS

How would you rate your pain in the last week without Pain Killers?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

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

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

PREVIOUS HEALTH CONDITIONS

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: Reactions here:

_____ _____

_____ _____

List the prescription drugs you are currently taking (or you may attach a list): (If more space is needed, please provide a list)

Name	Dose & How many times	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathies, etc.) as above: (If more space is needed, please provide a list)

Name	Dose & How many times	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please mark the area & type of pain on the drawings using the codes listed below.

N= Numbness T= Tingling S= Soreness P= Pain A= Ache ST= Stabbing B=Burning SH= Sharp