

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:	Arthritis In:	Surgery In:	_____ Implanted Cord	_____ High Cholesterol
_____ Back/ Neck	_____ Back/ Neck	_____	_____ Bladder Stimulator	_____ High Blood Pressure
_____ Shoulder Rt/Lt/Both	_____ Shoulder Rt/Lt/Both	_____	_____ Sciatica	_____ Pacemaker/Defibrillator
_____ Elbow Rt/Lt/Both	_____ Elbow Rt/Lt/Both	_____	_____ Pinched Nerve	_____ Herniated/ Bulging Disc
_____ Wrist Rt/Lt/Both	_____ Wrist Rt/Lt/Both	_____	_____ Poor Circulation	_____ Spinal Stenosis
_____ Hand Rt/Lt/Both	_____ Hand Rt/Lt/Both	Joint Replacement:	_____ Vascular Problems	_____ Degenerative Disc
_____ Hip Rt/Lt/Both	_____ Hip Rt/Lt/Both	_____	_____ Cancer	_____ Diabetes Type 1 / 2
_____ Knee Rt/Lt/Both	_____ Knee Rt/Lt/Both	_____	_____ Chemotherapy	_____ Numbness/Tingling
_____ Ankle Rt/Lt/Both	_____ Ankle Rt/Lt/Both	_____	Other _____	_____ Plantar Fasciitis Other
_____ Foot Rt/Lt/Both	_____ Foot Rt/Lt/Both	_____		

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 Physical Therapy Pain Medications Tylenol Ibuprofen Chiropractic
 Massage Therapy Steroid Injections Creams Other _____

Is this condition interfering with any of the following?

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

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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

