

Patient Application

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is *very unique and different*, highly specialized and advanced even compared to other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if *you are a case we can accept*. Please feel free to ask any questions if you need any assistance. ***We look forward to serving you.***

ABOUT YOU

Name: _____ Date: ___ / ___ / ___ Sex: M / F Birth Date: ___ / ___ / ___ Age: _____
 Address: _____ City _____ State _____ Zip _____
 Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
 Spouse's Name _____ Do you have children? Yes No How many? _____
 Email: _____ Employer: _____ How long? _____
 Occupation: _____ Standard Duties: _____
 How did you hear about our office (Please be specific)? _____

IN EVENT OF EMERGENCY

Emergency Contact: _____ Relationship to Patient: _____
 Home Phone: (____) _____ Other Phone: (____) _____
 Who is your Medical Doctor? _____ Phone: (____) _____
May we send an initial/final report to your MD of what we find during your visit? Yes No

INSURANCE INFORMATION

The front desk staff will **need** a copy of your **driver's license** and/or **insurance cards**.

HEALTH HISTORY

Please list anything you may be **allergic to**: _____
 List previous **surgeries** with dates: _____
 List any **past serious accidents** with dates: _____
 Family Health History: _____
 Do you: Take Supplements or Vitamins? Yes No Exercise? Yes No Are you on a special diet? Yes No Since: ___ / ___ / ___
 Do you smoke? Yes No How much? _____ How long? ___ Are you wearing: Heel lifts Sole lifts Inner soles Arch supports
 What age is your mattress? _____ Is it comfortable? Yes No Do you have a support pillow? Yes No How long? _____
For women: Are you taking Birth Control? Yes No Are you pregnant? Yes No How long? ___ Nursing? Yes No

REASON FOR YOUR VISIT

The reason for this visit is a result of (please circle): work, sports, auto, trauma, chronic pain, acute pain, or a wellness checkup
 Explain what happened: _____

CURRENT SYMPTOMS

Describe your symptoms below, in the order of severity. Describe only ONE symptom PER SECTION.

First Symptom	1. Check only one body location below ONSET: _____ <input type="checkbox"/> Headaches <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Back of Head <input type="checkbox"/> Jaw <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Eye <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Neck <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Mid Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Low Back <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Chest <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Abdomen <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Ribs <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Buttocks <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Upper Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B Other locations: _____	2. 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Types of pain <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Cutting <input type="checkbox"/> Throbbing <input type="checkbox"/> Burning <input type="checkbox"/> Numbing <input type="checkbox"/> Tingling <input type="checkbox"/> Cramping <input type="checkbox"/> Spasm <input type="checkbox"/> Stinging <input type="checkbox"/> Shooting <input type="checkbox"/> Pounding <input type="checkbox"/> Constricting 3. Pain Frequency <input type="checkbox"/> Up to 1/4 of awake time <input type="checkbox"/> 1/4 to 1/2 of time <input type="checkbox"/> 1/2 to 3/4 of awake time <input type="checkbox"/> Most all the time 4. Pain Intensity (How it affects daily activities) <input type="checkbox"/> Doesn't affect <input type="checkbox"/> Somewhat affects <input type="checkbox"/> Seriously affects <input type="checkbox"/> Prevents activities 5. Does this pain radiate into other body parts? <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Both</td> </tr> <tr> <td><input type="checkbox"/>Head</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Neck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Shoulder</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Arm</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Hand</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Hip</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Leg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Foot</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> Other locations of radiation: _____		Left	Right	Both	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other types of pain: _____ 6. Actions affecting this pain <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Brings On</td> <td style="text-align: center;">Aggravates</td> <td style="text-align: center;">Relieves</td> </tr> <tr> <td><input type="checkbox"/>In the A.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>In the P.M.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/>Bending forwrd.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td><input 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Have you **EVER** had any of the following diseases or conditions?

CERVICAL SPINE (Neck): Postural distortions from low nerve flow (causing Forward Head Syndrome) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent Colds/Flu's |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking |

THORACIC SPINE (Upper back): Postural distortions from low nerve flow (resulting from Forward Head Syndrome) in the upper back will weaken the nerves into your heart and lungs affecting these parts of your body. Do you experience...?

- | | |
|--|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/wheezing |
| <input type="checkbox"/> Tachycardia (heart beating rapidly) | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart attacks/Angina | <input type="checkbox"/> Pain on deep inspiration/expiration |

THORACIC SPINE (Mid back): Postural distortions from low nerve flow (resulting from Forward Head Syndrome) in your mid back will weaken the nerves into your chest/ribs and upper digestive tract affecting these parts of your body. Do you experience...?

- | | |
|--|---|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Hypoglycemia (altered blood sugar) |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |

LUMBAR SPINE (Low back): Postural distortions from low nerve flow (resulting from **Forward Head Syndrome**) in the low back will weaken the nerves into your legs/feet and pelvic organs affecting these parts of your body. Do you experience...?

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Menstrual irregularities/cramping(females) | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | |

Please list any other serious medical conditions not mentioned: _____

TREATMENT HISTORY

Fill in other doctor(s) seen prior to your first visit to this office for your current condition.

Dr. _____ How did you get there? Self Somebody else Ambulance Police
 First visit date: ___ / ___ / ___ Treatment Type: _____ Last visit date: ___ / ___ / ___
 How many treatments received? _____ Currently treating? Yes No Did treatments benefit you? Yes No
 X-rays done? Yes No Body parts X-rayed? _____
 Lab work done? Yes No What lab work? _____

Are you taking any of the following medications (over the counter or PRESCRIBED)?

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Nerve pills | <input type="checkbox"/> Pain killers (including aspirin) | <input type="checkbox"/> Muscle relaxers | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Anti-Inflammatories (NSAIDS) | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Other (list below): |

SYMPTOM HISTORY

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
 My current complaints DID exist before and ARE NOT worsened.
 My current complaints DID exist before and ARE worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
 My history HAS NOT contributed to my current symptoms.
 NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occurred _____ months ago years ago OR on Date: ___ / ___ / ___

Write in any other Prior Symptom History, not covered above: _____

ACTIVITIES OF DAILY LIVING ASSESSMENT

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty. **Only fill in areas affected.**

1 = "I can do it *without any difficulty*"

2 = "I can do it *without much difficulty*, despite some pain"

3 = "I manage to *do it by myself*, despite marked pain"

4 = "I manage to do it, despite the pain, but *only if I have help*"

5 = "*I cannot do it* all, because of the pain"

Difficulties with Self Care and Personal Hygiene Activities

Bathing Drying hair Brushing teeth Putting on shoes Preparing meals Taking out trash
 Showering Combing hair Making bed Tying shoes Washing hair Doing laundry
 Eating Washing face Putting on shirt Putting on pants Cleaning dishes Going to the toilet

Difficulties with Physical Activities

Standing Walking Kneeling Bending back Twisting left Leaning back
 Sitting Stooping Reaching Bending left Twisting right Leaning left
 Reclining Squatting Bending forward Bending right Leaning forward Leaning right
 Standing for long periods Sitting for long periods Walking for long periods Kneeling for long periods

Difficulties with Functional Activities

Carrying small objects Lifting weights off floor Pushing things while seated Exercising upper body
 Carrying large objects Lifting weights off table Pushing things while standing Exercising lower body
 Carrying brief case Climbing stairs Pulling things while seated Exercising arms
 Carrying large purse Climbing inclines Pulling things while standing Exercising legs

Difficulties with Social and Recreational Activities

Bowling Jogging Swimming Ice Skating Competitive Sports Dating
 Golfing Dancing Skiing Roller Skating Hobbies Dining Out

Difficulties with Traveling

Driving a motor vehicle Riding as a passenger in a motor vehicle Riding as a passenger on a train
 Driving for long periods of time Riding as a passenger on an airplane Riding as a passenger for long periods

Use the following **1 to 5** scale to describe the difficulties below:

1 = "This area is *not affected* by my condition"

2 = "This area is *slightly affected* by my condition"

3 = "My condition *moderately restricts* my ability in this area"

4 = "My condition *seriously limits* my ability in this area"

5 = "My condition *prevents* me from using this ability"

Difficulties with Different Forms of Communication

Concentrating Hearing Listening Speaking Reading Writing Using a keyboard

Difficulties with the Senses

Seeing Hearing Sense of touch Sense of taste Sense of smell

Difficulties with Hand Functions

Grasping Holding Pinching Percussive movement's Sensory discrimination

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep Being able to participate in desired sexual activity

ACCOUNT INFORMATION

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____

Adult Patient Parent Guardian Spouse