

PATIENT APPLICATION FOR TREATMENT

Please fill out the following form in as much detail as possible. Please print.

DATE: _____

Name _____ Date of Birth _____

Gender Female Male Marital Status M S W D Age _____ Social Security #: _____

Address _____ City _____ State: _____ Zip: _____

E-mail _____ Cell phone: _____

Referred By: _____ Home phone: _____

Occupation _____ Work phone: _____

Patient Employer/School: _____ Employer Phone: _____

Employer Address: _____ City _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Spouse's Name: _____ Birth date: _____

Spouse's Employer: _____ Spouse Phone: _____

How many children do you have? _____ What are their ages? _____ Are any other members of your family being treated in this office? Y N _____

Have you ever had chiropractic care before? Y N How long has it been? _____

Accident Information: Is condition due to an accident? Y N date: _____

Type of Accident: Auto work home other

If this is due to an accident please notify the office to obtain the correct additional form

Please describe below, in the following two sections, your primary, secondary, and additional reasons, if any, for seeking care in our office:

Primary Complaint (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily

() other: _____

Please grade the intensity of this problem (with 10 being worse):

At best 1 2 3 4 5 6 7 8 9 10 At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____

Please describe the location of the pain. _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Secondary Complaint -- if any (List one only): _____

When did you first experience this problem? _____

How did this problem first begin? _____

How often do your experience this problem? () 1-2x/week () 3-4x/week () 5-6x/week () daily

() other: _____

Please grade the intensity of this problem (with 10 being worse):

At best 1 2 3 4 5 6 7 8 9 10 At worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc)? _____

Please describe the location of the pain: _____

Does this problem cause pain to travel to any other area? Y N If yes, where? _____

Is this problem getting: () worse? () better? () staying the same?

What seems to aggravate this problem? _____

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? _____

Have you seen any other doctors for this problem? Y N If yes, who? _____

What treatment was given? _____

How effective was the care? _____

Which best describes your reason for consulting our office?

_____ I have a specific concern and require help with this concern

_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health

_____ I want to be healthier five years from now than I am today

Indicate if you have experienced or are currently experiencing the following and explain below if needed:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy/Sinus | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depressed | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Ruptures* |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Migraines | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Miscarriage* | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Auto Accidents* | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Sleeping Trouble |
| <input type="checkbox"/> 0-1 yrs | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> 1-5 yrs | <input type="checkbox"/> Foot Trouble/Pain | <input type="checkbox"/> Neck Pain or Stiffness | <input type="checkbox"/> Stress |
| <input type="checkbox"/> 5 or more | <input type="checkbox"/> Fractures | <input type="checkbox"/> Numbness or tingling in arms, hands, fingers | <input type="checkbox"/> Stroke* |
| <input type="checkbox"/> Back Pain or stiffness | <input type="checkbox"/> Frequent Cold/Flu | <input type="checkbox"/> Numbness or tingling in buttocks, legs, feet, toes | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Upper | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> R <input type="checkbox"/> L* | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Mid | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Numbness or tingling in buttocks, legs, feet, toes | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Lower | <input type="checkbox"/> Headaches | <input type="checkbox"/> R <input type="checkbox"/> L* | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease* | <input type="checkbox"/> Other accident/falls | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vision changes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pain when coughing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Parkinson's | _____ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched nerve | _____ |
| <input type="checkbox"/> Concentrating Difficulties | <input type="checkbox"/> High/low blood Pressure* | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Congenital Disease* | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Pregnant (now)* | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Impotence | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, twisting | <input type="checkbox"/> Irritable | <input type="checkbox"/> Prosthesis | |
| | <input type="checkbox"/> Jaw Pain or Click | <input type="checkbox"/> Psychiatric care | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | |

*Explanation of items checked above: _____

Date of Last: Physical Exam: _____ Spinal X-ray _____ Blood tests _____ Spinal Exam: _____

Urinalysis: _____ Dental X-ray: _____ MRI: _____ CT/Bone Scan: _____

Other special treatment: _____

Injuries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Medications	_____	_____

Allergies _____

Vitamins _____

Are you pregnant? Yes No Number of Pregnancies? ____ Miscarriages? _____

Lifestyle:

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

Do you smoke? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you drink coffee? Y N If yes, how much? _____

Do you drink tea? Y N If yes, how much? _____

Do you drink water? Y N If yes, how much? _____

How regularly do you exercise? () daily () ___ x/week () occasionally () never

What kind of exercise do you do? _____

How many hours of sleep do you get on average? _____ how many x's do you wake nightly: _____

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

Occupational _____ Personal _____

I understand and agree that Flow Chiropractic has the right to refuse to accept me as a patient at any time before treatment begins. The physical exam and x-rays are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept me as a patient. If x-rays or other studies are necessary before treatment begins I will be notified. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____ DATE: _____

FINACIALLY RESPONSIBLE PARTY OR INSURANCE INFORMATION

Name (Financially responsible): _____ D.O.B.: _____

Relationship to patient: _____ Ins. Company: _____

Group Number: _____ I.D. Number: _____

I certify that I and /or my dependants have insurance coverage with the insurance company state above and assign directly to Dr. Jill Aardema at Flow Chiropractic, LLC all insurance benefits if any, otherwise payable to me for services rendered. If I do not have insurance coverage or with a company that which Flow Chiropractic, LLC does not participate, then the services will be billed directly to the financially responsibly party. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. The consent will end when the current treatment plan or one year from the date signed below.

Signature of Patient, Guardian, or Personal Representative

DATE _____

Print name of Patient, Guardian, or Personal Representative.

Relationship to Patient _____

FOR DOCTORS USE ONLY

CC: _____ L

ocation: _____

Onset/Trauma: _____

Mechanism of Injury: _____

Duration: _____

Current Symptoms: Pain Numbness Stiffness Weakness other: _____

Location: Left / Right / Bilateral _____

Quality of Symptoms: burning diffuse dull/aching localized radiating sharp
 shooting stabbing throbbing tightness tingling
 other: _____

Level of Impairment Due to Symptoms (resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (with activity): 0 1 2 3 4 5 6 7 8 9 10

Worse in morning midday afternoon night activity rest

Better in morning midday afternoon night activity rest

Other Aggravating or Relieving Factors: _____

Present % during the day: 0% 10 20 30 40 50 60 70 80 90 100%

Visual Analogue Pain: 0 1 2 3 4 5 6 7 8 9 10 (best and worse)

Job Performance: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do)

Recreation: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do)

ADL's: _____

Past Health History: _____

Prior Interventions: _____

_____ Paternal:

_____ Maternal: