Today's Date: _____ Patient ID: _____

Application for Care

Whom may we thank for referring you to this office? _____

Patient Demographics

Name: _____ ❑ Male ❑ Female

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____

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

Home/Cell Phone: _____ Work Phone: _____

E-Mail Address: _____ Can we call you at work? ❑ Yes ❑ No

Occupation: _____ Employer: _____

Current Height: _____ Current Weight: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Name of Spouse or Significant Other: _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Health Insurance: ❑ Yes ❑ No Provider: _____

Do you have a Secondary Insurance? ❑ Yes ❑ No Provider: _____

(**IF YES**, please fill out the information below of the PRIMARY INSURED)

Name: _____ Birth Date: _____/_____/_____ ❑ Male ❑ Female

Social Security #: _____ Member ID #: _____

Group # (if applicable): _____

Is your condition the result of ANY type of accident? ❑ Yes ❑ No

(IF YES, please finish filling in the information in the box. IF NO, continue to the next section.)

If yes, Identify the type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other (please explain): _____

_____

Date of Accident: _____/_____/_____ Approximately what time of day? _____ AM _____ PM

Have you reported this accident to anyone? ❑ Yes ❑ No To Whom: _____

Who is your primary care physician? (Doctor and/or practice) _____

Do you have any pertinent medical records at another healthcare facility that would be useful for the Doctor that you do not have with you today? ❑ Yes ❑ No

If Yes, where? _____

HISTORY OF PRESENT ILLNESS(s)

PLEASE ADDRESS WHAT BRINGS YOU TO OUR OFFICE:

Chief Complaint: _____ Did the problem begin with an injury? ❑ Yes ❑ No

How long have you noticed this problem? _____ Are the symptoms constant or intermittent? _____

Have you suffered from this problem in the past? ❑ Yes ❑ No If yes, when? _____

Were you given a Diagnosis for THIS Condition by another health care provider? ❑ Yes ❑ No

If Yes, what was the Diagnosis? _____ Who provided the Diagnosis? _____

What treatments have you tried to help this problem? _____

Who provided the treatments and when? _____

What were the results? ❑ Favorable ❑ Unfavorable Please explain: _____

When is the problem at its worst? ❑ Morning ❑ Mid-Day ❑ Late Afternoon ❑ Evening ❑ Night-Time

What relieves your symptoms? _____ What makes it worse? _____

What activities are restricted because of this? _____

What is your current activity level vs. your usual or desired activity level? _____

Secondary Complaint: _____ Did the problem begin with an injury? ❑ Yes ❑ No

How long have you noticed this problem? _____ Are the symptoms constant or intermittent? _____

Have you suffered from this problem in the past? ❑ Yes ❑ No If yes, when? _____

Were you given a Diagnosis for THIS Condition by another health care provider? ❑ Yes ❑ No

If Yes, What Was the Diagnosis? _____ Who Provided the Diagnosis? _____

What treatments have you tried to help this problem? _____

Who provided the treatments and when? _____

What were the results? ❑ Favorable ❑ Unfavorable Please explain: _____

When is the problem at its worst? ❑ Morning ❑ Mid-Day ❑ Late Afternoon ❑ Evening ❑ Night-Time

What relieves your symptoms? _____ What makes it worse? _____

What activities are restricted because of this? _____

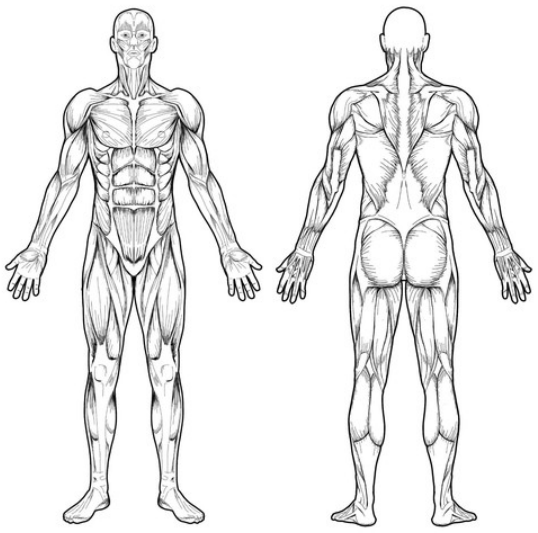
What is your current activity level vs. your usual or desired activity level? _____

Additional Complaint(s):

_____

*PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R = Radiating	B = Burning
D = Dull	A = Aching
N = Numbness	P = Pins/Needles
S = Sharp/Stabbing	T = Tingling



Family History:

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Arthritis _____ ❑ Autoimmune _____

❑ Cancer _____ ❑ Diabetes _____

❑ Heart Disease _____ ❑ Neurological Diseases_____

❑ Other _____

Medical History / Social History

Allergies: _____

Surgeries/When Performed: _____

Injuries/Occurrence: _____

Diseases: _____

Please check to indicate if you are currently or have ever experiencing any of the following conditions:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arm/Hand Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain/Stiffness
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Feet/Hands
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaw Problems
- ❑ Kidney Disease
- ❑ Leg/Knee Pain
- ❑ Light Bothers Eyes
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Body Temp
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain/Stiffness
- ❑ Nervousness
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Strep Throat
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Suicide Attempt
- ❑ Tension
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tubes in Ears
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Activities of Daily Living: Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

INDICATE which DAILY TASKS ARE AFFECTED and the LEVEL of PAIN EXPERIENCED (if pain is experienced):
No Pain (0), Tolerable Pain (3), Moderate Pain (5), Moderate/Severe Pain (7), Disabling Pain (10)

Walking____ Sitting____ Bending____ Standing____ Sleeping____ Lifting____ Running____ Climbing____

Carrying____ Pushing____ Driving____ Dressing____ Reading____ Chores____ Gardening____ Sports____

Working____ Dancing____ Rolling Over____ Computer Work____ Watching TV____ Sitting to Standing____

Does your work activity mostly involve? ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Social History:

Have you ever been exposed to mold? ❑ Yes ❑ No

Have you ever been exposed to chemicals (work, pesticides, etc.)? ❑ Yes ❑ No

Do you use birth control? ❑ Yes ❑ No What Type? _____

What is your daily/weekly intake of the following:

Caffeine: _____ cups/day

Alcohol: _____ drinks/week

❑ Cigarettes ❑ Cigar ❑ Pipe: _____ packs/day

Recreational Drug Use: ❑ Yes ❑ No _____ How Often?

Medication Name	Dosage	Reason

Supplement Name/Brand	Dosage	Reason

Sleep/Rest History:

Average number of hours you sleep: ❑ more than 10 ❑ 8 to 10 ❑ 6 to 8 ❑ less than 6

Do you have trouble sleeping? ❑ Yes ❑ No

Do you have problems falling asleep? ❑ Yes ❑ No

Do you have problems staying asleep? ❑ Yes ❑ No

Do you feel rested upon awakening? ❑ Yes ❑ No

Do you have problems with insomnia? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No

Do you use sleeping aids? ❑ Yes ❑ No If Yes, what? _____

Dental History:

Do you have (or had) any non-tooth colored fillings (ie silver or gold colored fillings)? ❑ Yes ❑ No How many? _____

Have you had any fillings removed? ❑ Yes ❑ No

Do you have any root canals? ❑ Yes ❑ No How many? _____

Other dental fixtures? ❑ Yes ❑ No Describe_____

Have you had any dental work in the last 12 months? Please describe.

_____

_____

Is there anything else you would like the Doctor to know?

_____

_____

_____

_____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: (X) _____ DATE: _____

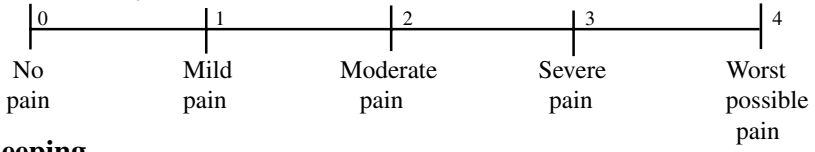
DOCTOR'S SIGNATURE: _____ DATE REVIEWED: _____

Functional Rating Index

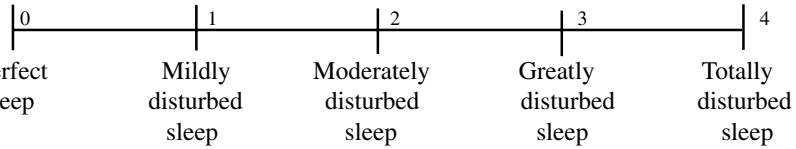
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

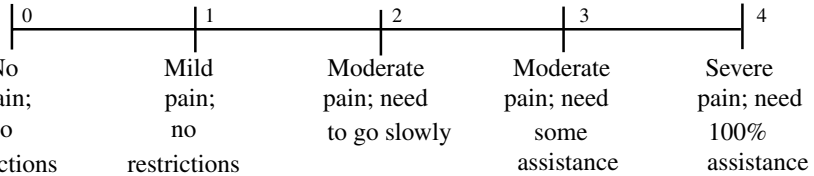
1. Pain Intensity



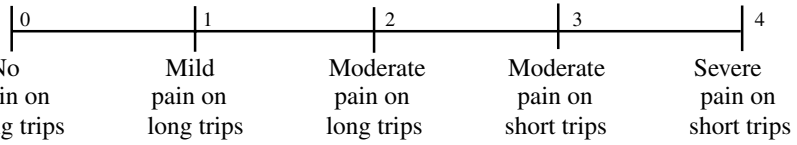
2. Sleeping



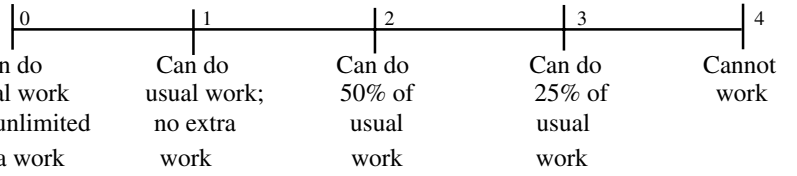
3. Personal Care (washing, dressing, etc.)



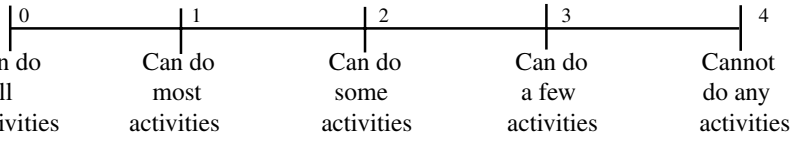
4. Travel (driving, etc.)



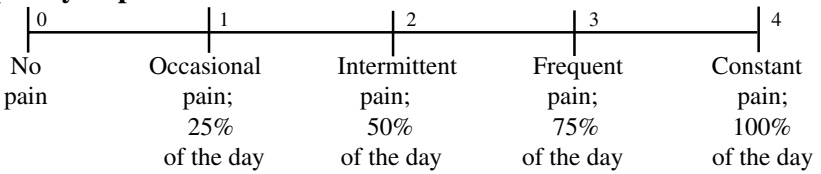
5. Work



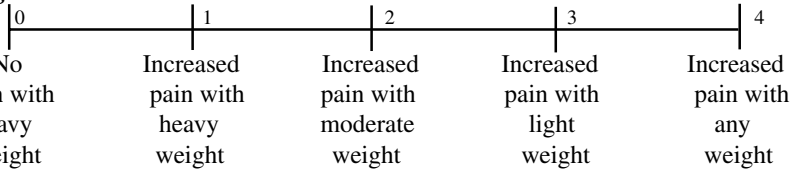
6. Recreation



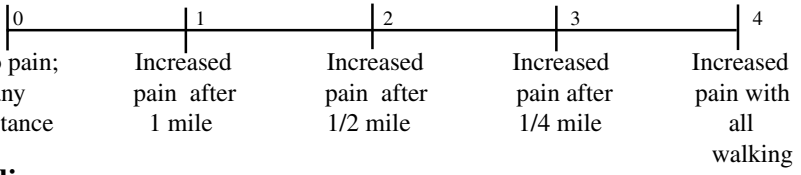
7. Frequency of pain



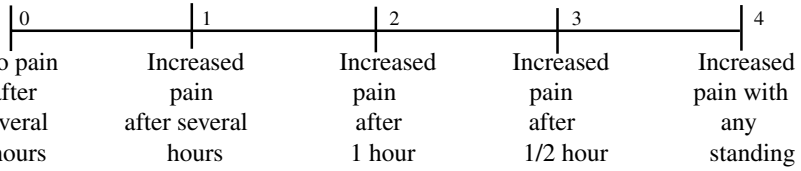
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total _____
Eyes	_____	Watery or Itchy Eyes
	_____	Swollen, Reddened or Sticky Eyelids
	_____	Bags or Dark Circles Under Eyes
	_____	Blurred or Tunnel Vision (does not include near or far-sighted)
		Total _____
Ears	_____	Itchy Ears
	_____	Earaches, Ear Infections
	_____	Drainage from Ear
	_____	Ringing in Ears, Hearing Loss
		Total _____
Nose	_____	Stuffy Nose
	_____	Sinus Problems
	_____	Hay Fever
	_____	Sneezing Attacks
	_____	Excessive Mucus Formation
		Total _____
Mouth/ Throat	_____	Chronic Coughing
	_____	Gagging, Frequent Need to Clear Throat
	_____	Sore Throat, Hoarseness, Loss of Voice
	_____	Swollen or Discolored Tongue, Gums, or Lips
	_____	Canker Sores
		Total _____
Skin	_____	Acne
	_____	Hives, Rashes, Dry Skin
	_____	Hair Loss
	_____	Flushing, Hot Flashes
	_____	Excessive Sweating
		Total _____
Heart	_____	Irregular or Skipped Heartbeat
	_____	Rapid or Pounding Heartbeat
	_____	Chest Pain
		Total _____

Lungs	_____	Chest Congestion
	_____	Asthma, Bronchitis
	_____	Shortness of Breath
	_____	Difficulty Breathing

Total _____

Digestion	_____	Nausea, Vomiting
	_____	Diarrhea
	_____	Constipation
	_____	Bloated Feeling
	_____	Belching, Passing Gas
	_____	Heartburn
	_____	Intestinal/Stomach Pain

Total _____

Joints/	_____	Pain or Aches in Joints
Muscles	_____	Arthritis
	_____	Stiffness or Limitation of Movement
	_____	Pain or Aches in Muscles
	_____	Feeling of Weakness or Tiredness

Total _____

Weight	_____	Binge Eating/Drinking
	_____	Craving Certain Foods
	_____	Excessive Weight
	_____	Compulsive Eating
	_____	Water Retention
	_____	Underweight

Total _____

Energy/	_____	Fatigue, Sluggishness
Activity	_____	Apathy, Lethargy
	_____	Hyperactivity
	_____	Restlessness

Total _____

Mind	_____	Poor Memory
	_____	Confusion, Poor Comprehension
	_____	Poor Concentration
	_____	Poor Physical Condition
	_____	Difficulty in Making Decisions
	_____	Stuttering or Stammering
	_____	Slurred Speech
	_____	Learning Disabilities

Total _____

Emotions	_____	Mood Swings
	_____	Anxiety, Fear, Nervousness
	_____	Anger, Irritability, Aggressiveness
	_____	Depression

Total _____

Other	_____	Frequent Illness
	_____	Frequent or Urgent Urination
	_____	Genital Itch or Discharge

Total _____

Grand Total _____