Patient Application for Treatment

TODAY'S DATE_____ ACCOUNT #_____

NAME_____GENDER_____DATE OF BIRTH_____AGE_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____MOBILE PHONE_____Are you a full time student? ☐ YES ☐ NO

MARITAL STATUS: S M D W NAME OF SPOUSE_____ # OF CHILDREN_____ AGES_____

EMAIL_____ HEIGHT_____'_____"_ WEIGHT _____LBS_

OCCUPATION_____EMPLOYER_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR? ☐ YES ☐ NO HOW LONG HAS IT BEEN? _____

SOCIAL SECURITY # _____-_____-_____ WHO REFFERED YOU TO OUR OFFICE? _____

IN CASE OF AN EMERGENCY: CONTACT_____PHONE_____

PRIMARY INSURANCE:_____ SECONDARY INSURANCE:_____

HAVE YOU EVER SUFFERED OR BEEN DIAGNOSED AS HAVING:

Y	N	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

*Explanation_____

_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

NAME OF YOUR FAMILY DOCTOR_____PHONE_____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

_____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING:

☐ TUBERCULOSIS ☐CANCER ☐ HEART CONDITION ☐ DIABETES

IF YES, PLEASE EXPLAIN _____

_____

_____

For Doctor's Use Only

General:

Injury Type:

Drug Allergies:

See Meds Addendum

Date _____

Acct _____

Patient _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

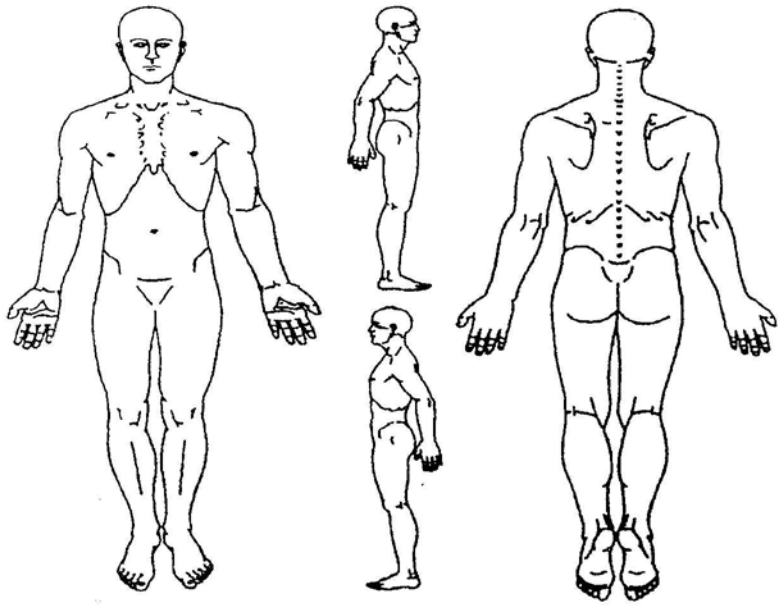
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below, please **circle** the **percentage of time** you experienced your **main complaint**:

	Occasional			*Intermittent*			*Frequent*			*Constant*
0	10	20	30	40	50	60	70	80	90	10

4. How long have you been experiencing your **main complaint**?_____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ☐ AM ☐ PM How long does it last?_____ Mins_____Hrs
7. What makes it feel better?_____
8. What makes it feel worst? _____
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ Be hospitalized ☐ Been treated by another chiropractor ☐ Been treated by another specialty provider ☐ Never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No Dates? _____To_____
12. Are you pregnant? ☐ Yes ☐ No
13. What was the first day of your last menstrual cycle?_____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

_____ Personal Care_____ Lifting_____ Reading_____ Concentrating_____ Work_____ Driving_____ Sleeping
_____ Recreation _____ Walking_____ Sitting_____ Standing_____ Social Life

Patient Signature _____ **Date** _____

DATE _____

ACCT _____

PATIENT _____

System Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

High Blood Pressure _____
Dizziness/Fainting _____
Insomnia _____
Low Resistance _____
Tension _____
Confusion _____
Fatigue _____
Ulcers _____
Eye/Vision Problems _____
Ear/Hearing Problems _____
Difficulty Breathing _____
Heart Problems _____
Loss of Bladder Control _____
Constipation _____
Diarrhea _____
Digestion Problems _____
Nausea _____
Female Problems _____
Prostate Problems _____
Diabetes _____
Hands/Feet Cold _____
Hand Tremors _____
Loss of Memory _____
Nervousness _____
Sweaty Palms _____
Speech Difficulty _____
Anxiety _____
Depression _____
Irritability _____

For Doctor's Use Only

DR.

REVIEWED SYSTEMS	SYMPTOMS
_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity.
_____ Skin	Rashes, Eruptions, changes in warts or moles, pigmentation changes, bruising, itching hair loss, nail changes.
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimination, redness, discharge
_____ Nose	Rhinorrhea, expistaxis, allergies, airway obstruction.
_____ Mouth& Throat	Ulcers, tooth pain, extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat.
_____ Neck	Stiffness, lumps, swelling, masses, pain
_____ Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats.
_____ Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope.
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
_____ Breasts	Self-examination, frequency, results, pain, nipple discharge, lumps, masses, skin dimpling.
_____ Gastrointestinal	Unusual diet, dysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
_____ Genitournary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia.
_____ Endocrine	Polydipsia, polphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstruation, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric.
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain
_____ Musculoskeletal	Bone, joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy.
_____ Neurological	Cranial Nerve defects, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia.
_____ Psychological	Mood swings, depression, anxiety, phobias.

Problem/ Medication List

Dr.Name/Facility	Problem	Type of Treatment	From When to When?	Name of Medication/Vitamin	Who Prescribed Dr / Self

Insurance Patients

Our office does not guarantee that your insurance will pay. We will make every effort, at the beginning of your health care, to receive verification of your policy and it's benefits. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

I Authorize the Release of any Medical Information Necessary to Process the Claim.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the checks to me and mail it as follows:

Beaumont Chiropractic

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THEM FOR SERVICES RENDERED

*SIGNED (Insured or Authorized Person)*_____*Date*_____

Consent To Treatment of Minor Child

I hereby authorize Beaumont chiropractic and whomever may designate as his assistant(s) to administer chiropractic care as he deems necessary to my _____(*indicate relationship to child*).

Name:_____

Address:_____

_____

Date:_____

Signed:_____
Parent or Guardian

Witnessed:_____

Date:_____

I _____, in signing this form, state to the best of my knowledge there is no **pregnancy** (*confirmed or suspected*) at the time this service was performed.

_____
Patient's Signature

_____
Witness