Hartley Chiropractic Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

Section 1: Patient Information **Appt. Date:** _____ **Referred By:** _____

Name (first, middle, last): _____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ___/__/_____ Age: _____

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

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer: _____ Occupation: _____ Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children:_____

Emergency Contact: _____ Relationship:_____ Phone #(____)_____

Section 2: History of Complaint

Primary Complaint(s):_____

Secondary Complaint(s):_____

Are your complaints due to an Accident? ☐ Yes ☐ No If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident:_____If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No

Who was it reported to? _____ Have you seen any doctors for this condition: ☐ Yes ☐ No

Please list the doctor specialty and for how long you were seen_____

_____

List any medications you currently take (Prescription and non-prescription)_____

_____

_____

Section 3: Family History

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ☐ No ☐ Yes

If yes, whom and what condition(s): _____

_____

Section 4: Chiropractic History

Have you ever seen a Chiropractor before? ☐ Yes ☐ No When _____/_____/_____

For what reason were you seen? _____ Were you helped? ☐ Yes ☐ No

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 5: Past Trauma History *Starting from birth, we all experience thousands of physical, mental, and chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, and traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3,000 lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end 10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐ Lt ☐ Rt

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐ Lt ☐ Rt

B. Sports Injuries (If there are too many to list please write the name of the sport and "MANY" next to it.)

Example: **1-1-2008** ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt ☐ Rt

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt ☐ Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips and falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice and bruised Left Elbow**

Date:___/__ /_____ Type of Injury: _____ ☐ Lt ☐ Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt ☐ Rt

D. Repetitive Injuries (Please list **all** repetitive injuries you've had in the past.)

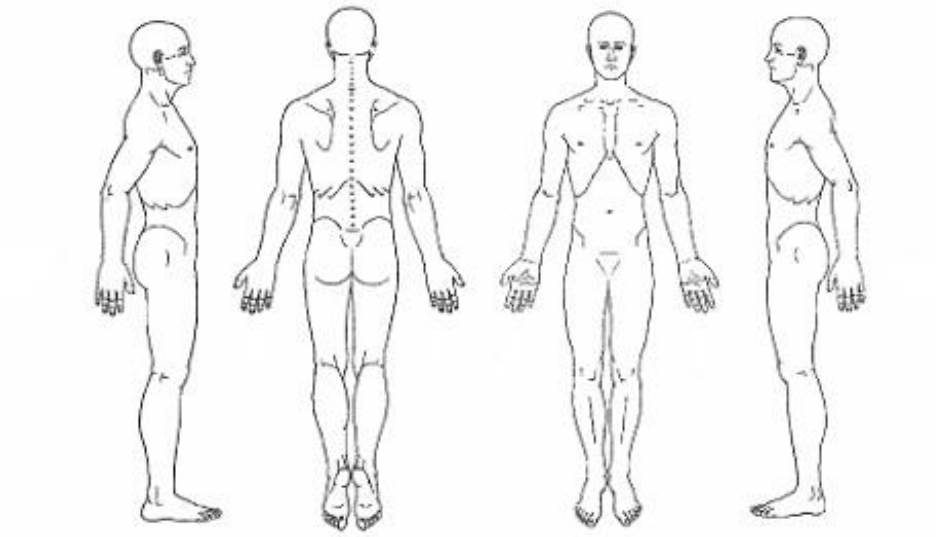
Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

Date:___/__ /_____ Type of Injury: _____ ☐ Lt ☐ Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt ☐ Rt

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

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 6: Present and Past Conditions
Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R and L***.

P = **P**ast Health Issue **C** = **C**urrent Health Issue **N** = **N**ever had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☐ R ☐ L

Extremeties	**Location**	**Immune System**	**Male**
___Hip ☐Pain ☐Stiff	☐ R ☐ L	___Skin Problems	___Impotence
___Knee ☐Pain ☐Stiff	☐ R ☐ L	___Sinus Problems/Allergies	___Prostate Problems
___Foot ☐Pain ☐Stiff	☐ R ☐ L	___Frequent Colds/Flu	**Female**
___Shoulder ☐Pain ☐Stiff	☐ R ☐ L	___Anemia	___Menopausal Problem
___Elbow ☐Pain ☐Stiff	☐ R ☐ L	___Other:_____	___Menstrual Cycle Problems
___Wrist ☐Pain ☐Stiff	☐ R ☐ L	**Organ Problems or Dysfunction**	**Social History**
___Jaw Pain ☐Pain ☐Stiff	☐ R ☐ L	___Diabetes	___Smoking
___Swollen Or Painful Joints		___Liver Trouble	How much_____
Spine		___Hepatitis	How often_____
___Head/Shoulders Feel Heavy/Tired		___High/Low Blood Pressure	___Alcoholic Beverage Consumption
___Neck Pain Stiff	☐ R ☐ L	___Heart	Occurs _____
___Upper Back Pain Stiff	☐ R ☐ L	**Other Conditions**	Recreational Drugs
___Mid Back Pain Stiff	☐ R ☐ L	___Headaches/Migranes	What Used_____
___Low Back Pain Stiff	☐ R ☐ L	___Trouble Sleeping	How Often_____
___Pain with cough, sneeze, or strain with bowel movement. LOCATION of pain_____		___Excessive Sweating ___ Cancer and Type:_____ _____	___Exercise Type_____ How Often_____
Other:_____ _____ _____		___Emotional/Mental Disorders	
		___Learning Disability	
		___Nervous/Irritable	
Numbness/Tingling or Pain In		___Loss of Memory	
___Arm	☐ R ☐ L	___Dizziness/Loss of Balance	
___Hand/Fingers	☐ R ☐ L	___Arthritis	
___Legs	☐ R ☐ L	___Epilepsy/Convulsions	
Respiratory		___Knocked Unconscious	
___Asthma		___Frequent Ear Infections	
___Chest Pain		___Ringing in Ear ☐R ☐L	
___Difficulty Breathing		___Hearing Loss ☐R ☐L	
___Lung Problems		___Trouble Concentrating	
___COPD		___HIV/AIDS	
Diegestion		___Fracture/Dislocation of Bones:_____	
___Heartburn		Other_____ _____	
___Digestion Problems		**Urinary Tract**	
___Gallbladder Problems		___Kidney Trouble	
___Colon Trouble		___Frequent Urination	
___Diarrhea/Constipation		___Bedwetting	
___Hemorrhoids		Other:_____ _____	

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 7: Functional Assessment: Check any activities of life that your current conditions are affecting:

- ☐ Sitting
- ☐ Sit to Stand
- ☐ Standing
- ☐ Walking
- ☐ Driving
- ☐ Sleep/Rolling
- ☐ Reading
- ☐ Computer Use
- ☐ Yard work/Gardening
- ☐ Running
- ☐ Climbing
- ☐ Pushing/Pulling
- ☐ Dressing/Shaving
- ☐ Dishes/Laundry
- ☐ Bending
- ☐ Lifting
- ☐ Exercising/Sports

Doctors Notes: _____

_____

Section 8: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: ***when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain).***

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident_____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty and for how long you were seen._____

List any past hospitalizations and/or surgeries:

Surgeries:_____

List hospitalizations other than surgeries:_____

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____Date Form Reviewed: _____/_____/_____