

Please fill out the application entirely and legibly. We need all information for insurance purposes.

**Name** \_\_\_\_\_ **Nickname** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

*\*We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you\**

**Date of Birth** \_\_\_\_\_ **Social Security** \_\_\_\_\_

*\*If you have Medicare, we need you to list your SSN above or provide us with the Medicare card\**

**Spouse's Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Your Occupation** \_\_\_\_\_ **Retired?** Yes  No

## REVIEW OF SYMPTOMS

### ➔ Please check all that apply

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Foot Pain     | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Spinal Stenosis   | <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Pinched Nerve                 |
| <input type="checkbox"/> Hand Pain     | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Degenerative Disc | <input type="checkbox"/> Chemotherapy                      | <input type="checkbox"/> Poor Circulation              |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Arthritis in Hands                | <input type="checkbox"/> Joint Replacement             |
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Leg Pain          | <input type="checkbox"/> Arthritis in Feet                 | <input type="checkbox"/> Foot Surgery                  |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Herniated Disc          | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Implanted Cord/Bladder Stimulator | <input type="checkbox"/> Poor wound healing            |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Bulging Disc            | <input type="checkbox"/> Morton's Neuroma  | <input type="checkbox"/> Sciatica                          | <input type="checkbox"/> Excessive thirst or urination |

## PRESENT HEALTH CONDITION

➔ In order of importance, list the health problems you are most interested in getting corrected:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

➔ List approximately how long you have noticed these problems:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

➔ Is there a certain time of day any of these problems are better or worse?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

➔ List the things you have used for these problems:

*Gabapentin Neurontin Lyrica Cymbalta  
Physical Therapy Pain Medications Aleve  
Tylenol Ibuprofen Motrin Chiropractic  
Massage Therapy Injections Creams*

➔ Is your balance/walking ability affected? *If yes, please describe:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

➔ What do you think is causing your problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of all doctors you have seen for these problems and treatment you received:

\_\_\_\_\_

➔ **Have your symptoms:**     Improved     Worsened     Stayed the same

List anything that makes your condition worse \_\_\_\_\_

\_\_\_\_\_

List anything that makes your condition better \_\_\_\_\_

\_\_\_\_\_

➔ **How would you describe the symptoms? Please check ALL that apply**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Aching Pain   | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Hot Sensation   | <input type="checkbox"/> Cramping        |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Tingling            | <input type="checkbox"/> Throbbing Pain  | <input type="checkbox"/> Swelling        |
| <input type="checkbox"/> Sharp Pain    | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Dead Feeling    | <input type="checkbox"/> Burning         |
| <input type="checkbox"/> Tiredness     | <input type="checkbox"/> Heavy Feeling       | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Electric Shocks |

➔ **Is this condition interfering with any of the following?**

- |  |                                  |   |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep                   | <input type="checkbox"/> Work    | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing         |

## SOCIAL HISTORY

**Do you smoke?**    Yes  No     If yes, how many cigarettes daily? \_\_\_\_\_

**Do you drink?**    Yes  No     If yes, how many drinks per week? \_\_\_\_\_

**Do you exercise regularly?**    Yes  No     If yes, please describe type & how often: \_\_\_\_\_

\_\_\_\_\_

## CURRENT PAIN LEVELS

➔ **How would you rate your pain in the last week?**

NO PAIN    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**    WORST PAIN POSSIBLE

➔ **If you had to accept some level of pain after completion of treatment, what would be an acceptable level?**

NO PAIN    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**    WORST PAIN POSSIBLE

PREVIOUS HEALTH HISTORY/HEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name \_\_\_\_\_ Signature \_\_\_\_\_

Please give name, address, and office phone number of your primary care physician.

Name \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

When were you last seen there?

\_\_\_\_\_

May we send them updates on your treatment/condition? Yes  No

List ALL allergies/sensitivities to medication, food, and other items here:

<i>Item you react to:</i>	<i>Reaction:</i>
_____	_____
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

<i>Name</i>	<i>Dose (mg or IU)</i>	<i>Times Daily</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____