Name _____ Date of Birth _____

Siskin Family Chiropractic & Wellness

Better Life Through Natural Wellness

Patient Application Form

☐ ***I am an adult***

WELCOME and THANK YOU for applying as a patient in our clinic. We are a unique clinic specializing in spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health, even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we understand your condition. To achieve this, we will perform the necessary tests to establish an optimal program for your health goals. You will be accepted as a patient when we are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

☐ ***I am a child / minor***

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. Our office provides pediatric services in much the same manner as adult services. Spinal pediatric adjusting and postural rehabilitation has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

Patient Name _____ Parent/Guardian Name _____

Signature _____

Date Completed _____

Please fill in your name and date of birth at the top of each page and initial each page in the box at the bottom.

Name _____ Date of Birth _____

Personal Information

First Name _____ Middle Name _____ Last Name _____

What name or nickname should we use when we speak with you? _____

Address _____

City _____ State _____ Zip _____

Mobile Phone _____ Mobile Phone carrier _____

Home Phone _____ Business Phone _____

Email _____

What was the name of the person or organization who referred you to our office? _____

Gender _____ Date of Birth _____ Age _____

Occupation _____ Employer _____ Years at current job _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow)

Spouse/Partner Name _____

Spouse/Partner Occupation _____ Employer _____ Years at current job _____

Handedness ☐ Right ☐ Left

Height _____ Has height changed since age 18 and if so, how much? _____

Weight _____ Weight at age 18 _____

Weight before first pregnancy _____

Emergency Contact

Name _____ Relationship _____

Contact Information (please provide a minimum of 2 methods of contact ie. mobile phone and other phone or email)

_____

Child(ren) name(s) and age(s):

Child 1 _____ Child 2 _____ Child 3 _____ Child 4 _____

Do you have grandchildren? _____ How many? _____ What is their age range? _____

How many live within driving distance of your home? _____

Healthcare Professionals you utilize:

Professional 1 Name _____

Type of Doctor/Clinician _____ City _____ Date of most recent visit _____

Professional 2 Name _____

Type of Doctor/Clinician _____ City _____ Date of most recent visit _____

Professional 3 Name _____

Type of Doctor/Clinician _____ City _____ Date of most recent visit _____

Professional 4 Name _____

Type of Doctor/Clinician _____ City _____ Date of most recent visit _____

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Name _____ Date of Birth _____

Goals and Circumstance

Have you ever been treated by a chiropractor? ☐ Yes ☐ No

When was your most recent chiropractic treatment? _____

Were you referred to our office by another chiropractor? ☐ Yes ☐ No

If not listed above, please provide the name and location of your chiropractor.

_____

_____

What technique or style of practice did your chiropractor utilize? _____

Does this style or technique work well for you? ☐ Yes ☐ No

What was the reason for being referred to our office? _____

What is your primary goal for success in our office? _____

Is your current complaint from an injury or accident? ☐ Yes ☐ No

What was the onset date of your current injury or concern? _____

If an injury, did it occur at work or in an automobile? ☐ Yes ☐ No

If so, please fill out the section on auto accidents or work injury (pages 13 & 14).

Briefly describe your physical habits during a typical work-day. What percentage of the time do you sit versus stand versus walk or perform physically demanding activities?

_____

_____

Please provide a list of hobbies and preferred activities as well as how often you participate in them.

_____

_____

How often and what type of physical activity do you perform on a regular basis? How does this exercise seem to impact your health?

_____

_____

Please list activities you used to enjoy but have either stopped or modified because of any physical limitation.

_____

_____

_____

_____

_____

_____

Name _____ Date of Birth _____

Health Profile

Have you ever been a smoker? (Includes Vaping)

☐ Never ☐ Currently Smoke ☐ More than 15 years ago ☐ Less than 15 years ago Date quit _____

Current smoking description: How much/ How Often? _____

Do you drink alcohol? ☐ Yes ☐ No How much/ How Often? _____

Do you drink coffee? ☐ Yes ☐ No How much/ How Often? _____

Do you take vitamins and or any nutritional supplements? ☐ Yes ☐ No Please describe: _____

_____

_____

Family Health History (Write None under Health Conditions if alive and healthy with no current health conditions)

	Health Conditions	Cause	Age at Passing	Cause of passing
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				
Sibling 4				

Please list any additional significant family health history:

_____

_____

_____

_____

_____

_____

_____

_____

Health Profile (continued on next page)

Name _____ Date of Birth _____

Health Profile (continued)

Current Medications:

	Medication Name	Condition	Dosage	Frequency	Start Date	Predicted End Date
Medication 1						
Medication 2						
Medication 3						
Medication 4						
Medication 5						
Medication 6						
Medication 7						
Medication 8						

*** Our understanding is the CDC of the USA indicates that when someone takes more than 4 prescription medications, it becomes nearly impossible to understand how they alter body chemistry and function. We look at cases where greater than four medications are taken as being more complex. ***

Please list any additional medications and reason for taking them:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Health Profile (continued on next page)

Name _____ Date of Birth _____

Health Profile (continued)

Medication Allergies:

	Medication	Reaction
Medication Allergy 1		
Medication Allergy 2		
Medication Allergy 3		
Medication Allergy 4		

Seasonal Allergies:

	Allergy	Reaction, and improving or worsening over time?
Seasonal Allergy 1		
Seasonal Allergy 2		
Seasonal Allergy 3		
Seasonal Allergy 4		

Additional seasonal allergy notes:

_____

Food allergies/Sensitivities:

	Food	Reaction
Food 1		
Food 2		
Food 3		
Food 4		

Do you participate in a special diet or have particular dietary restrictions? ☐ Yes ☐ No

How long has this been true? _____

Please describe, along with the reason for any restrictions.

_____

_____

_____

Health Profile (continued on next page)

Name _____ Date of Birth _____

Health Profile (continued)

History of Surgery:

	Procedure Description	Date of Surgery	For Condition	Outcome Positive?	Current Restrictions
Surgery 1				☐ Yes ☐ No	
Surgery 2				☐ Yes ☐ No	
Surgery 3				☐ Yes ☐ No	
Surgery 4				☐ Yes ☐ No	

Please list any additional surgeries:

_____

History of Trauma:

Please provide an account of physical trauma including childhood injuries, sports injuries, broken bones, sprains, strains, etc.

_____

	Date/Age occurred	Describe event	Still causes restriction or symptoms?
Trauma 1			
Trauma 2			
Trauma 3			
Trauma 4			

Please list any additional trauma:

_____

Have you been diagnosed with any of the following?

☐	Diabetes	☐	Varicose Veins	☐	Neurological Problems	☐	Lung Disease	☐	Rheumatic fever	☐	Circulatory Problems
☐	Stroke	☐	Heart Murmur	☐	High Blood Pressure	☐	Heart Disease	☐	Cancer	☐	Osteoporosis
☐	Kidney Disease	☐	Paralysis	☐	Migraine Headaches	☐	Arthritis	☐	Liver Disease	☐	Metal Implants
☐	Infectious Disease	☐	Gall Bladder	☐	Broken bones/ fractures	☐	Appendectomy	☐	Tonsillectomy	☐	Hernia
☐	Pneumonia/ Bronchitis	☐	Polio	☐	Tuberculosis	☐	Anemia	☐	Whooping Cough	☐	Chicken Pox/ Shingles
☐	Mumps	☐	Measles	☐	Thyroid Problems	☐	Small Pox ____ Influenza	☐	Pleurisy	☐	Blood Sugar Problems
☐	Epilepsy/Seizures	☐	Eczema/Psoriasis	☐	Lumbago						
☐	Other:										

Health Profile (continued on next page)

Name _____ Date of Birth _____

Spinal Health

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread, ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1]

Please answer the following questions accurately so we may determine the full extent of your condition.

Cervical Spine (Neck)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please circle (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

N P	Neck Pain	N P	Headaches	N P	Sinusitis
N P	Pain in shoulders/arms/hands	N P	Dizziness	N P	Allergies/Hay fever
N P	Numbness/tingling in arms/hands	N P	Visual disturbances	N P	Recurrent colds/Flu
N P	Hearing disturbances	N P	Coldness in hands	N P	Low Energy/Fatigue
N P	Weakness in grip	N P	Thyroid conditions	N P	TMJ/Pain/Clicking

Please explain: _____

_____

Thoracic Spine (Upper Back)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please circle (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

N P	Heart Palpitations	N P	Recurrent Lung Infections/Bronchitis	N P	Heart Murmurs
N P	Asthma/Wheezing	N P	Tachycardia	N P	Shortness Of Breath
N P	Heart Attacks/Angina	N P	Pain On Deep Inspiration/Expiration	N P	Mid Back Pain
N P	Nausea	N P	Diabetes	N P	Pain in Ribs/Chest
N P	Ulcers/Gastritis	N P	Hypoglycemia/Hyperglycemia	N P	Indigestion/Heartburn
N P	Reflux	N P	Tired/Irritable after eating or when not having eaten for a while		

Please explain: _____

_____

_____

_____

_____

_____

_____

Spinal Health (continued on next page)

[1]Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.
[2]Include a list of modern research showing the same...

Name _____ Date of Birth _____

Spinal Health (continued)

Lumbar Spine (Low back)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please circle (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

N	P	Pain in hips/legs/feet	N	P	Weakness/injuries in hips/knees/ankles	N	P	Low back pain
N	P	Numbness/tingling in legs/feet	N	P	Recurrent bladder infections	N	P	Coldness in legs/feet
N	P	Frequent/difficulty urinating	N	P	Muscle cramps in legs/feet	N	P	Sexual dysfunction
N	P	Constipation/Diarrhea	N	P	Menstrual irregularities/cramping (females)			

Please explain: _____

_____

Other _____

Please list any health conditions not mentioned:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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_____

Name _____ Date of Birth _____

Current Condition

Do you suffer from bleeding or clotting issues/disorders? ☐ Yes ☐ No

If you cough, sneeze or strain, do you experience any pain? ☐ Yes ☐ No

Do you experience any significant fevers or night sweats? ☐ Yes ☐ No

Do you have problems or history with shortness of breath or chest pain? ☐ Yes ☐ No

Please Explain: _____

_____

On a scale of 1-10 where 10 indicates the worst possible pain level and 1 indicates feeling well, indicate your problem areas below:

Location	**Worst Level**	**Best Level**	**Frequency** (25%, 50%, 75%, 100%)	**Worst time of day** (Morning, Mid-day, Evening)	**Triggering Activity**

In general, check one of the following statements:

☐ This problem is improving rapidly ☐ This problem is improving slowly

☐ This problem remains the same

☐ This problem is worsening gradually ☐ This problem is worsening rapidly

Discomfort Intensity:

☐ Comes and goes ☐ Varies ☐ Does not vary ☐ Is mild

☐ Is moderate ☐ Is fairly severe ☐ Is severe ☐ Worst imaginable pain

My discomfort is relieved by (please explain): _____

_____

Indicate your ability to perform the following activities:

(For any limitations, circle L - limited D - difficult P - painful)

L D P	personal care	L D P	lifting	L D P	bending	L D P	stooping
L D P	pushing	L D P	pulling	L D P	climbing	L D P	walking
L D P	sitting	L D P	reading	L D P	driving	L D P	standing
L D P	reaching	L D P	gripping	L D P	kneeling	L D P	balance
L D P	fatigue	L D P	sleeping	L D P	socialize/hobbies	L D P	concentration/work
L D P	family/home life	L D P	eating/breathing				

Please fill in Symptom Chart on the following page:

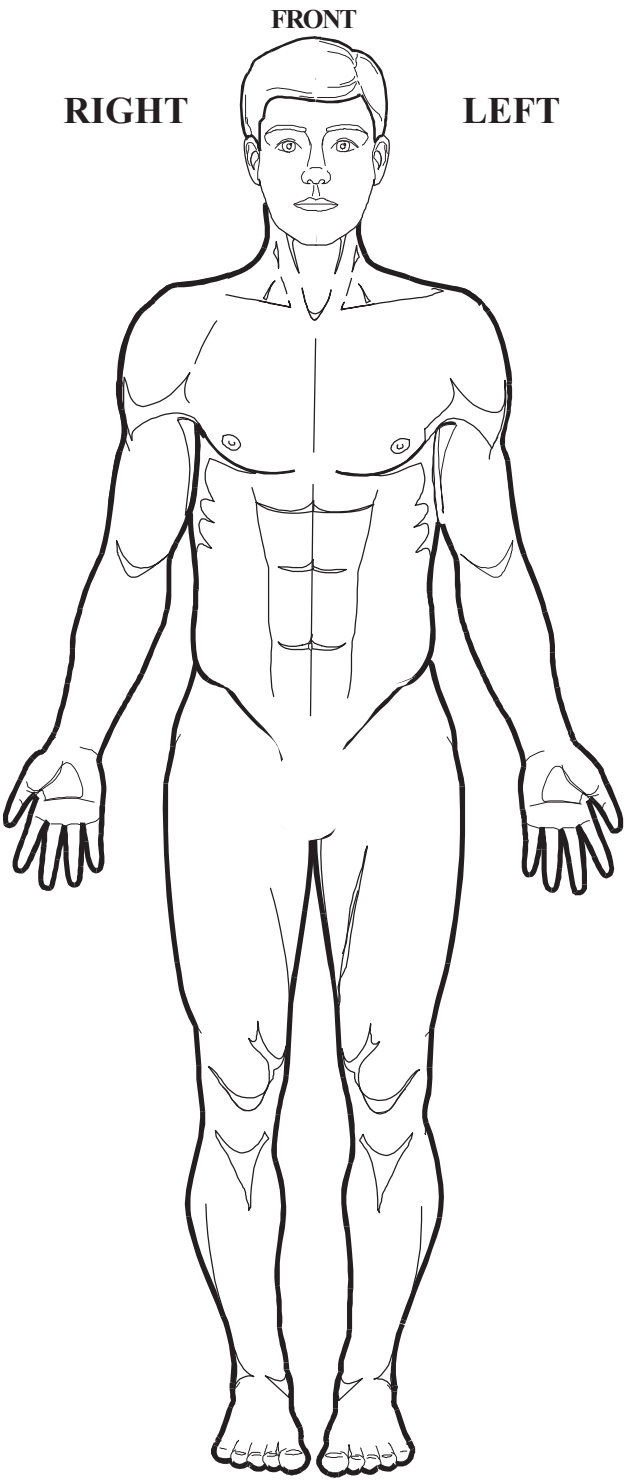
Name _____ Date of Birth _____

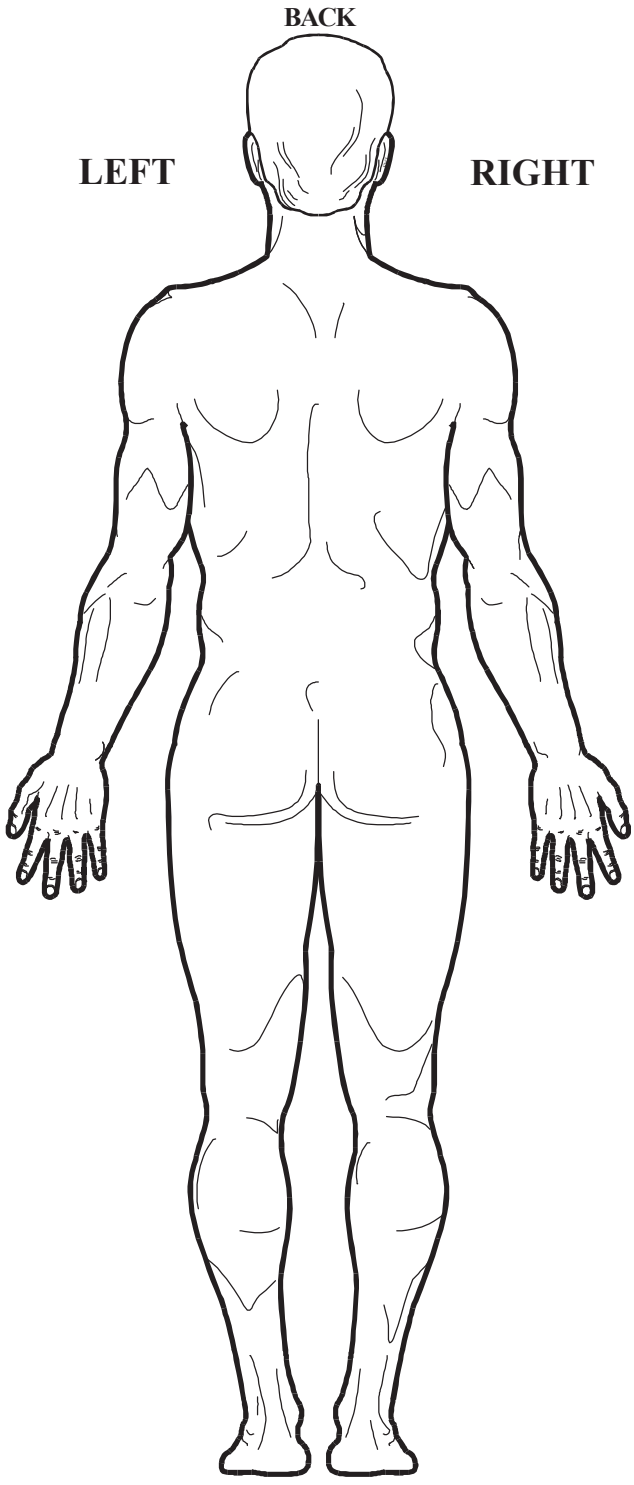
SYMPTOM CHART

PLEASE COMPLETE THE FOLLOWING ***SYMPTOM CHART*** BY USING LETTERS AT THE LEFT TO INDICATE YOUR AREAS OF PAIN ON THE DIAGRAM:

P. PAIN
T. TINGLING
N. NUMBNESS
B. BURNING
S. STIFFNESS

PATIENT'S SIGNATURE: _____





Name _____ Date of Birth _____

If you are over 18 and not involved in an accident, you are finished with this form!

Children and Minors

History of Trauma

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (if you check an item with an asterisk, please offer a detailed explanation):

☐ Fell from a height of two (2) feet or more as an infant

☐ Experienced a fall that left a bruise or lump on their head or other resulting trauma*

☐ Rough shaking as an infant

☐ Were involved in a car accident (if you check this item, please ask the front desk person for the corresponding form)

☐ Experience broken bones or debilitating injuries*

☐ Difficult Birth (see below)

Explanation of (*) item(s):_____

_____

_____

Birth Experience

How long was labor? _____

Describe any complications:

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Vacuum Extraction ☐ Forceps Assistance

Vaccination History

Please describe your child's vaccination history: _____

_____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

	Response	Vaccination		Response	Vaccination
☐	Swelling, redness, heat/hardness of site		☐	Body rash or hives	
☐	High fever (over 103 degrees)		☐	High-pitched screaming	
☐	Extreme sleepiness or unresponsiveness		☐	Body twitching or paralysis	
☐	Breathing problems (asthma, etc.)		☐	Excessive bleeding or anemia	
☐	Head banging		☐	Excessive diarrhea or chronic constipation	
☐	Loss of memory/foggy state		☐	Muscle weakness	
☐	Chronic ear or respiratory Infections		☐	Vision or hearing disturbances	
☐	Joint pain		☐	Crossing of eyes	
☐	Seizures				
☐	Other (please explain)				

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Name _____ Date of Birth _____

Auto/Work Injury Information:

Date of Accident: Date ____/____/____ Location of Accident (City) _____

Describe in your own words how the accident occured: _____

_____

Auto Accident Information:

Auto Information:

Auto Insurance Carrier _____ Address _____

Id# _____ Did you report this accident to your insurance carrier? ☐ Yes ☐ No

When _____ To whom? _____

Place of impact on your vehicle _____ Speed of your vehicle _____

Type of your vehicle Did the air bag deploy? ☐ Yes ☐ No

Speed of other vehicle _____ Type of other vehicle _____

Choose: ☐ My vehicle struck the other vehicle ☐ The other vehicle struck my vehicle

My vehicle was impacted in the: ☐ Front ☐ Right side ☐ Left side ☐ Rear

At the time of impact were you: ☐ Looking straight ahead ☐ Looking right ☐ Looking left

Were you wearing a seat belt? ☐ Yes ☐ No Did you strike anything in the vehicle? ☐ Yes ☐ No

If yes, describe: _____

What was your position in the car? ☐ Driver ☐ Passenger Were both hands on the wheel? ☐ Yes ☐ No

Was your foot on the brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Passenger: What was your position in the vehicle? ☐ Front ☐ Right Rear ☐ Left Rear ☐ Other _____

Workers Compensation Information:

Did you report this accident to your foreman or supervisor? ☐ Yes ☐ No

When? _____ Name _____

Workmans Compensation Insurance Carrier _____

Address _____

Describe Injury: _____

_____

_____

_____

_____

Auto/Work Injury Information (continued on next page)

Name _____ Date of Birth _____

Auto/Work Injury Information (continued)

General Accident Information:

Immediately following the accident, how did you feel? _____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to the hospital? ☐ Yes ☐ No

When? _____ By ambulance? ☐ Yes ☐ No Name of hospital _____

Address _____ Were you attended by a doctor? ☐ Yes ☐ No

Were you x-rayed? ☐ Yes ☐ No If so, what diagnosis was made? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What type of treatment was provided? _____

What reccomendations were made? _____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Name _____

Address _____

What treatment was provided? _____

Do you have an attorney handling this case? ☐ Yes ☐ No Name _____