Schultz Chiropractic, Acupuncture & Rehab

Application for Care

First Name:______________________________ Middle Initial:__________________
Last Name:______________________________ **Nick Name:**_________________
Date and Year of Birth:____________________ **Age:**_________
Address:____
City:____________________________________ State:___________ Zip:_____________

Cell Phone:_(_______)-___________________________

Can we use texting for appointment reminders, missed and rescheduled visits, and/or leave messages with you rather than calling you? **Yes** **No**

How did you find our office?

____ Referral from friend, relative or co-worker
____ Clinic Monument Sign and/or building
____ Internet Search
____ Referral from a doctor or therapist
____ Other: ___________________________

Personal email address: ____

Your Occupation:_______________________________________
Your Employer:____
Physically requires me to:____

Spouse and Emergency Contacts:

Spouse:____
Spouse's Occupation:____________________________________
Employer:____
In case of Emergency, contact:____________________ Phone:______________________
Primary Medical Physician:_______________________ City:________________________
Last seen (approximately):______________________________

Surgeries:

1.____
2.____
3.____
4.____
5.____

Medications:

1.__________________________ Reason:________________________
2.__________________________ Reason:________________________
3.__________________________ Reason:________________________
4.__________________________ Reason:________________________
5.__________________________ Reason:________________________

Prior Chiropractic Care:

Have you had prior chiropractic treatments? Yes No
Chiropractor:____________________________ City:______________________
Last seen (approximately): _______________ For:_____________________________
What you liked most about any prior chiropractic :____________________________

My main health complaint today: ____________________________________

CONCERNING MY COMPLAINT: (check all that apply)

___ It is painful
___ It is annoying
___ It is getting worse
___ It is getting better
___ It is staying the same
___ It is hard to enjoy life
___ It affects my home life
___ It affects my recreation
___ It affects my rest and sleep
___ It affects my job performance
___ It affects my mood

Things you have tried before seeing us today:

_____ Medical Visit _____ Muscle Relaxant _____ Anti-inflammatory
_____ Pain killers _____ Over-the-counter medicine ___ Massage
_____ Other chiropractor ___ Heat ___ Ice ___ Other:____________________

Diagnostic Options:

MINIMAL: _____ I feel my complaint is minor.

GENERAL: _____ I feel my complaint is more than minor. It has been with me for more than a month, or it is getting worse, or it is very painful. I would like a more thorough exam and x-ray.

UNDECIDED: _____ Before I choose, I would like to have a consultation with the doctor and let him decide what he thinks is best for me.

Types of Care Options:

(Choose the one that most fits your situation. Check one):

_____ **Relief Care:** Relief care is that necessary to get rid of your symptoms, but not the cause of it. It is the same as drying the floor that is wet from a leak, but not fixing the leak.

_____ **Corrective Care:** Corrective care differs from relief care in that it's goal to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in it's length or time, but is more long lasting.

Name:____ Date:_________________

Primary Reason for consulting our clinic:_____________________________

Circle your areas of concern, <u>then number them in order of importance:</u>

Headaches Neck Trapezius Upper Back Mid-back Low Back Buttock

Shoulder Arm Elbow Wrist Hand Knee Left Leg Right Leg

Ankle Foot Migraines Insomnia Anxiety Depression Vertigo

How long has this been going on:____
Why did this begin:____
Injuries, accidents, car accidents, sports injuries, falls or traumas that you remember in your past:
____

Have you experienced a same or a similar problem in the past: Yes No
Do you have recurring episodes: Yes No

What makes your primary problem worse:

___ Sitting ___ Lifting ___ Coughing
___ Standing ___ Twisting ___ Sneezing
___ Bending ___ Movement
___ Work ___ Sleep

What makes your primary problem better:

___ Sitting ___ Standing ___ Not doing very much
___ Heat ___ Walking ___ Limiting my normal activities
___ Ice ___ Not moving ___ Lay on my back

Describe the feeling in your primary area:

_____ Pain _____ Achy Pain _____ Sharp _____ Burning Pain ____ Tight _____ Stiff
_____ Spasm _____ Tingle _____ Numb _____ Pins and Needles Other:___________