Back in Motion Family Chiropractic Center

New Patient Application

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based 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 know the cause of your condition, that we can perform
the necessary tests to establish an optimal rehab program for you, and 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.

Patient Name _____

Date Completed _____

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: (_____

City, State, Zip: _____ Work Phone: (

Email Address: _____ Cell Phone: _____

Birth Date:_____, _____, _____Social Security #:_____ _____Marital Status: S M D W

Occupation:_____Employer Name: _____

Spouse's Name:_____Work Phone: (_____Cell Phone: (_____

Spouse's Employer:_____Occupation: _____

How were you referred to this office? _____ _____ _____ _____ _____ _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? q Yes q No If yes, when:_____, _____, _____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin?_____/_____, _____Are they: q Constant q Intermittent q Activity-related

Are they getting worse? q Yes q No Do they interfere with: q Work q Sleep q Hobbies q DailyRoutine

Explain:_____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? q Yes q No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? q Yes q No

If yes, explain: _____

Have you been treated for this? q Yes q No When were you last treated?_____, _____, _____

Who did you see? _____ _____ _____

What treatment was performed? _____ _____ _____ _____ _____ _____ _____

___ How did you respond?

_____

Experience with Chiropractic

Have you seen a Chiropractor before? q Yes q No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? q Yes q No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? q Yes q No Did they recommend a Home Health Care program? q Yes q No If yes, what?_____How long were you treated?_____Last treatment:_____, _____

How did you respond? _____

Are you aware of any poor posture habits? **YES or NO** Is there any history of spinal problems in your family? **YES or NO**

If yes, explain: _____

Health & Lifestyle

Do you exercise? What activities? Do

q Yes q No How often?_____day(s) per week; Other: _____

q Walking q Running/Jogging q Weight Training q Cycling q Yoga q Pilates q Swimming q Other: _____

q Yes q No How much? / How often? _____ _____

Do you smoke? q YES q No How much? / How often? _____

Do you drink coffee? q Yes q No ___ How much? / How often?

Do you take any supplements (i.e. vitamins, minerals, herbs)?_____ _____

If yes, please list:----------

Health Conditions

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 indicate (NJ= Now, (PJ = Past next to all conditions you've experienced or both if applicable.

_____Neck Pain	_____Headaches	_____Sinusitis
____ Pain in shoulders/arms/hands	____Dizziness	____Allergies/Hay fever
____ Numbness/tingling in arms/hands	____Visual disturbances	____Recurrent colds/Flu
____ Hearing disturbances	____Coldness in hands	____LowEnergy/Fatigue
____ Weakness in grip	____Thyroid conditions	____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 indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations	____Recurrent Lung Infections/Bronchitis
_____ Heart Murmurs	____Asthma/Wheezing
____ Tachycardia	____Shortness Of Breath
____ Heart Attacks/Angina	____Pain On Deep Inspiration/Expiration

Please explain: _____

Health Conditions *continued* ...

Thoracic Spine (Mid Back)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid 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 indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Nausea
____ Diabetes
____ Pain in Ribs/Chest
____ Ulcers/Gastritis
____ Hypoglycemia/Hyperglycemia
____ Indigestion/Heartburn
____ Reflux
____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

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

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

Please explain: _____

Other:

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

Please list any surgeries (include type of surgery and date it was performed): _____