# Patient Application Survey

Name _____ Date _____

Age _____ Date of Birth _____ ☐ Male ☐ Female SSN: _____

Address: _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Employed By _____ Work Phone _____

Insured By _____

Name of Spouse _____ E-mail Address _____

How did you hear about us? _____

## PURPOSE OF THIS VISIT

Reason for this visit _____

Is this purpose related to an auto accident? ☐ Yes ☐ No

Describe _____

When did this condition begin/when did you first notice it? _____

Describe _____

What activities aggravate your symptoms? _____

Is there anything which has relieved your symptoms? ☐ Yes ☐ No

Describe _____

Have you experienced this condition before? ☐ Yes ☐ No

Describe _____

Who did you see for this? _____

What did they do? _____

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No

Who? _____

When? _____

Reason for visits _____

How did you respond? _____

Did you know your posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor postural habits? ☐ Yes ☐ No

# HEALTH LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? _____

What activities? _____

Do you smoke? ☐ Yes ☐ No How much? _____

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

Do you drink coffee? ☐ Yes ☐ No How many cups/day? _____

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

# HEALTH CONDITIONS

**CERVICAL SPINE (NECK):**

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Coldness in Hands
- ☐ Thyroid Conditions
- ☐ SleepProblemss
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurrent Colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking
- ☐ Irritability

**THORACIC SPINE (UPPER BACK)**

- ☐ Heart Palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/Angina
- ☐ Recurrent lung infections/bronchitis
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

**THORACIC SPINE (MID BACK):**

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Tachycardia
- ☐ Indigestion/Heartburn
- ☐ Hypoglycemia
- ☐ Tired/irritable after eating or when you haven't eaten for a while
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ WeightTrouble

**LUMBAR SPINE (LOW BACK):**

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

# IN CASE OF EMERGENCY CALL

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Cell Phone _____

Relative not living with you _____ Phone _____

## Past Health History:

Previous illnesses you've had in your life

_____

Previous Injury or Trauma:

_____

Have you ever broken any bones? Which?

_____

Allergies:

_____

Medication & Reason for taking

_____

**Surgeries:**
Type of Surgery & Date

_____

**Family Health History:**
Health problems of relatives

_____

**Deaths in immediate family**:
Cause of parents or siblings death Age at death

_____

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I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Wayne Johnson D.C./Johnson Chiropractic for services performed.

Patient's Signature

or Guardian _____ Date _____

## Please fill out the following for all of your sysmtpms as completely as possible

**Symptom # 1** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

**Symptom # 2** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

**Symptom # 3** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

**Symptom # 4** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

**Symptom # 5** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day

**Symptom # 6** _____

**On a scale from 0-10, with 10 being the worst, please indicate the number that best describes the symptom most of the time:** Pain Scale _____

**What percentage of the time you are awake do you experience the above symptom at the above intensity**

**Percent of time** _____

**When did the symptom begin?** _____

**Did the symptom begin** ☐ Gradually ☐ Suddenly

**How did the symptom begin?** _____

**What makes the symptom worse? (check all that apply):**

☐ Sitting ☐ Standing ☐ Getting up from sitting ☐ Walking ☐ Running ☐ Lifting ☐ Driving
☐ Bending neck forward ☐ Bending neck backward ☐ Tilting head to left ☐ Tilting head to right
☐ Turning head to left ☐ Turning head to right ☐ Bending forward at waist ☐ Bending backward at waist
☐ Tilting left at waist ☐ Tilting right at waist ☐ Any movement ☐ Nothing

Other _____

**What makes the symptom better? (check all that apply):**

☐ Ice ☐ Heat ☐ Stretching ☐ Rest ☐ Massage ☐ Pain medication ☐ Exercise ☐ Muscle relaxers
☐ Chiropractic treatments ☐ Nothing Other _____

**Describe the quality of the symptom (check all that apply):**

☐ Dull ☐ Achy ☐ Nagging ☐ Burning ☐ Sharp ☐ Shooting ☐ Stinging ☐ Throbbing
☐ Piercing ☐ Stabbing ☐ Deep ☐ Pinching Other _____

**Does the symptom radiate to another part of your body** ☐ Yes ☐ No

**If yes, where does the symptom radiate?** _____

**Is the symptom worse at certain times of the day or night? (check one)**

☐ Morning ☐ Afternoon ☐ Evening ☐ Unaffected by time of day