

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS

APPLICATION FOR CARE

Name _____ Date: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred By _____ E-mail _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Marital Status S M D W SSN _____

Spouse's Name _____ Spouse's Occupation _____ # of Children/Ages _____

Previous chiropractor _____ Approx. date of last visit _____

Chiropractic techniques you've had success with _____

If pregnant, how many weeks? _____ Name of OB/midwife _____

Yes	No	(Birth – Age 5)	Patient Comment if answer is Yes	Chiropractor's Comment
		1. Pregnancy		
		Did your mother:		
<input type="checkbox"/>	<input type="checkbox"/>	Smoke or drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have a proper diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise through her pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have any falls or injuries during pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any physical and/or mental abuse?	_____	_____
		2. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breech/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
		3. Growth and Development		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you roll out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breastfed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____	_____

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Chiropractor's Comment
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught proper body movement and care?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery or organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (Prescriptive or non-prescriptive)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems?	_____	_____
		Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back	_____	_____

Reason for visiting us _____

Pain or problem started on _____

Pains are Sharp Dull Constant Intermittent Getting worse? Yes No

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? Yes No Sleep? Yes No Routine? Yes No

Other doctors seen for condition _____

Any home remedies? _____

What have you heard about chiropractic care? _____

Do you know what a subluxation is? Please describe _____

What daily rituals for spinal health do you practice? _____

Other symptoms:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Fever | <input type="checkbox"/> Buzzing in Ears |