

# 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? \_\_\_\_ Due Date \_\_\_\_\_ Name of OB/midwife \_\_\_\_\_

**The information in this section pertains to your history from birth to age 5, if you don't know just write "D.K."**

<b>Yes</b>	<b>No</b>		<b>Patient Comment if answer is Yes</b>	<b>Chiropractor's Comment</b>
		<b>1. Your mother's pregnancy with you</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Was she in good health 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?	_____	_____
		<b>2. Birth Process</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long or difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
		Forceps or Cesarean? Breech? Circle one if it applies	_____	_____
		Home birth? Hospital birth? Circle one	_____	_____
		<b>3. Growth and Development</b>		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed? Did you fall down the stairs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breastfed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents? Falls? Injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery? Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sat down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____	_____

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Chiropractor's Comment
<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"/>	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, eye or hearing problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress? Mental Stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas or problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	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"/> Buzzing in the ears | <input type="checkbox"/> Ears Ring                | <input type="checkbox"/> Fever           |