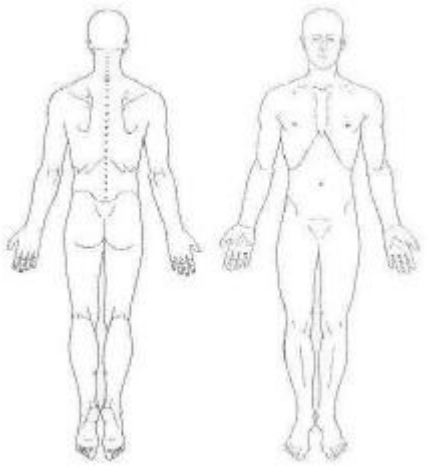
APPLICATION FOR CARE AT THIELE CHIROPRACTIC & WELLNESS

Patient Information

First Name: _____ MI: _____ Last Name: _____ Nick Name: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: (check one) ☐Male ☐Female
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: ( ) _____ Home/Work Phone: ( ) _____
Email: _____ (*I authorize my doctor to contact me via the email address provided)*
Referred By: ☐Patient/Friend ☐Physician ☐Advertisement ☐Community/Sports Event ☐ Website/Online Search
Name of Person or Event: _____ (We like to say Thank You to the person who referred you)
Marital Status: ☐Single ☐Married ☐Other Spouse's Name: _____ # of Children and ages: _____
Name of Parent or Legal Guardian (if patient is under 18): _____
Employer Name: _____ Occupation: _____ ☐Retired ☐Student
Race: (check one)
☐White ☐Black/African American ☐Hispanic ☐American Indian/Alaskan Native
☐Asian ☐Native Hawaiian or other Pacific Island ☐Other: _____ ☐I choose not to specify
Ethnicity: (check one) ☐Hispanic or Latino ☐Not Hispanic or Latino ☐I choose not to specify
Preferred Language: _____
Emergency Contact Information: Full Name: _____
Relationship: _____ Phone Number: ( ) _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance policy name, if any? _____ Insured's Name: _____ Insured DOB: _____/_____/_____
Insurance policy number: _____ Group Number: _____
Method of payment for this visit: ☐Cash ☐Check ☐Credit card

Patient Condition

Reason(s) for visit: _____
Is this condition due to an accident? ☐Yes ☐No ☐Auto ☐Work ☐Home ☐Other: _____ Date: _____/_____/_____
What was the mechanism of accident/injury? _____
When did your symptoms appear? _____ Is it constant or does it come and go? _____
How often do you have this problem? _____ How long does the pain last? _____
Does the pain radiate? ☐Yes ☐No If yes, explain: _____
Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation
Activities or movements that are difficult / painful to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down
Mark an "X" on the picture where you are experiencing symptoms ----------→



Circle your pain on the below scale of 0 to 10:

At rest:

No Pain	0	1	2	3	4	5	6	7	8	9	10	*Extreme Pain*

With Activity:

No Pain	0	1	2	3	4	5	6	7	8	9	10	*Extreme Pain*

My current pain / problem can be described as: **(check all that apply)**

☐ Dull	☐ Sharp	☐ Numb	☐ Tightness
☐ Achy	☐ Stabbing	☐ Tingling	☐ Spasm
☐ Stiffness	☐ Shooting	☐ Burning	☐ Pressure
☐ Soreness	☐ Pinching	☐ Other: _____	

What time of day is the problem worse? ☐Morning ☐Mid day ☐ As day progresses ☐Night ☐N/A
My current pain / problem seems to be: ☐Getting better ☐Staying the same ☐Getting worse ☐N/A
Explain: _____

Have you had the same or similar pain/problem in the past? ☐Yes ☐No If Yes: How many times? _____
When was the last episode? _____ How did the injury happen? _____
What treatment have you already received for your condition?
☐Medications ☐ Surgery ☐Physical Therapy ☐Chiropractic Care ☐None How long ago? _____
Name of other doctor(s) who have treated you for this condition and how: _____
_____
Were you satisfied with the results of your treatment? ☐Yes ☐No Explain: _____
_____

Allergies

Are you allergic to any medication(s)?
☐Yes ☐No If yes, list medications: _____
_____

Other known allergies:

☐Latex	☐Shellfish	☐Peanuts	☐Dairy

Other: _____
Reaction: _____

Smoking History

Do you smoke tobacco of any kind?
☐Yes ☐Former Smoker ☐Never been a smoker
If yes, how often do you smoke:
☐Current every day ☐Current sometimes
If yes, circle your level of interest in quitting smoking?
0 1 2 3 4 5 6 7 8 9 10
No interest **Very Interested**

Medications

Current medications, including frequency and dosage if known. **If there are no current medications, check here:** ☐

	Medication Name	**Quantity/Dosage** (i.e. 1 tablet/5 mg)	**Frequency** (i.e. 2 times/day)	**Start Date**
1				
2				
3				
4				
5				

****If you take more medications than you can list above please provide the staff with a full list of medications****
Do you currently use any recreational drugs? ☐Yes ☐No

Social History

WORK ACTIVITY:

What is your job description: _____
What do you do most of the day at work? ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor ☐Other: _____
How would you describe the physical stress level at work? ☐Low ☐Medium ☐High

EDUCATION:

Mark the highest level of education completed:
☐High School ☐GED ☐Vocational School ☐Associates Degree
☐Bachelors Degree ☐Graduate Degree ☐Doctorate ☐Other: _____

DIET / NUTRITION:

Are you on any special diet? ☐Yes ☐No If yes, for what reason: _____
Is your weight a concern for you? ☐Yes ☐No
Have you gained or lost over 10 pounds in the past 6 months without wanting to? ☐Yes ☐No
My dietary intake consists mainly of the following: (check all that apply)

☐Fruits	☐Vegetables	☐Whole Grains	☐High Fiber	☐Low Fiber
☐High Salt	☐Low Salt	☐High Sugar	☐Low Sugar	☐Low Carbohydrate
☐High Fat	☐Low Saturated Fats	☐High Protein	☐Low Protein	☐Low Calorie

How many meals do you eat per day? ☐Less than 3 ☐3 ☐greater than or equal to 4
How many 8 ounce glasses of water do you drink per day? _____
Alcohol Use: Now? ☐Yes ☐No If Yes # of drinks/week: _____ In the past? ☐Yes ☐No If Yes # of drinks/week: _____
How many coffee caffeine drinks do you drink a day? ☐Cups _____ ☐None
How many soda/energy drinks do you drink a day? ☐Cans _____ ☐None
Please list any vitamins/supplements you currently take: _____
_____

HEALTH REVIEW:

How many hours of sleep are you getting per night? ☐Less than 5 ☐6-8 ☐8-10 ☐10 or more hours
How would you rate your sleep on the following scale?

Wake Fully Rested	0	1	2	3	4	5	6	7	8	9	10	**No/Poor Sleep**

How many days a week do you exercise for 30 minutes or more? ☐0 ☐1-2 ☐3-4 ☐5-6 ☐7
How would you rate the intensity of your exercise?

High Intensity	0	1	2	3	4	5	6	7	8	9	10	**No Exercise**

How would you rate your physical stress level?

No Stress	0	1	2	3	4	5	6	7	8	9	10	**Very Stressed**

How would you rate your emotional stress level?

No Stress	0	1	2	3	4	5	6	7	8	9	10	**Very Stressed**

List your major stressors: _____
What are your health goals? _____

In Addition: Talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use.

Personal Health History

Are you currently under the care of a Healthcare Provider or any other doctor? Yes No
If yes, for what condition(s): _____
_____
Provider's Name: _____ Phone Number: ( ) _____
Has any doctor diagnosed you with Hypertension (high blood pressure) recently? Yes No Date Diagnosed: _____
Has any doctor diagnosed you with Diabetes recently? Yes No Date Diagnosed: _____
If yes, is your Diabetes under control? Yes No With? Diet Modification Medication Insulin
Has any doctor diagnosed you with any other disease? Describe: _____

Do you wear any of the following? ☐Heel Lefts ☐Innersoles ☐Arch Supports ☐Orthotics ☐Other: _____
For how long? _____ Were they prescribed by a doctor? ☐Yes ☐No
Have you seen a chiropractor in the past? ☐Yes ☐No Date of last visit: _____
If yes, name and location of previous chiropractor: _____ Phone Number: ( ) _____
Were you satisfied with your care? ☐Yes ☐No Why? _____
_____

Date of last:	Chiropractic Exam		Blood Work	
	Spinal X-ray		Mammogram	
	MRI / CT Scan		Pap Smear	
	Bone Density Scan		Prostate / PSA	

CHILDHOOD ILLNESSES / CONDITIONS:

☐ADD	☐Chicken Pox	☐Headaches	☐Psoriasis
☐Allergies / Hay fever	☐Chron's / Colitis	☐Hepatitis	☐Scoliosis
☐Anemia	☐Depression	☐HIV	☐Seizures
☐Asthma	☐Diabetes	☐Measles	☐Spina Bifida
☐Bedwetting	☐Ear infections	☐Mumps	☐Other: _____

IMMUNIZATIONS:

☐All recommended vaccines	☐Influenza	☐Tetanus
☐Adenovirus	☐IPV (polio)	☐Varivax (chicken pox)
☐DTaP (diphtheria, tetanus, pertussis)	☐MMR (measles, mumps, rubella)	☐Other: _____
☐Haemophilus B	☐Pneumonia	☐Not vaccinated
☐Hepatitis B	☐Rotavirus	

ADULT ILLNESSES:

☐ADD	☐CRPS (RSD)	☐Fibromyalgia	☐Lupus Erythema	☐Scoliosis
☐Alzheimer's	☐CVA (stroke)	☐Heart Disease	☐Multiple Sclerosis	☐Seizures
☐Arthritis	☐Cystic Kidney Disease	☐Hepatitis	☐Parkinson Disease	☐Shingles
☐Asthma	☐Depression	☐HIV	☐Pleural Effusion	☐Suicide attempt(s)
☐Cancer	☐Diabetes	☐High blood pressure	☐Pneumonia	☐Thyroid problems
☐Chicken Pox	☐Eczema	☐Liver Disease	☐Psoriasis	☐Vertigo
☐Colitis	☐Emphysema	☐Lung Disease	☐Psychiatric Condition	☐Other: _____

INJURIES: (List date next to injury)

☐Back injury	☐Fall (severe)	☐Laceration (severe)
☐Broken bones	☐Fracture	☐Motor vehicle accident
☐Disability(ies)	☐Head injury/Concussion	☐Other: _____

SURGERIES:

	Date:	Procedure:	Description:	Type: (circle)
1				**Inpatient / Outpatient**
2				**Inpatient / Outpatient**
3				**Inpatient / Outpatient**
4				**Inpatient / Outpatient**
5				**Inpatient / Outpatient**

Family History

Does anyone in your family suffer with the same or similar condition(s) or any hereditary condition(s)? ☐Yes ☐No

If Yes, whom? ☐Grandmother ☐Grandfather ☐Mother ☐Father ☐Sister(s) ☐Brother(s) ☐Daughter(s) ☐Son(s)

Please describe the condition(s): _____

Have they ever been treated for their condition(s)? ☐Yes ☐No ☐I don't know

Please list any hereditary conditions the doctor should be aware of: _____

Review of Symptoms

Please indicate if you have any of the following by checking the box.

Constitutional	☐**None**	☐Daytime drowsiness	☐Fever	☐Night sweats
	☐Chills	☐Fatigue	☐Loss of appetite	☐Weight gain / loss
Eyes / Vision	☐**None**	☐Cataracts	☐Itching	☐Wear contacts/glasses
	☐Blindness	☐Double vision	☐Photophobia	☐Eye problems
Ears, Nose, & Throat	☐**None**	☐Ear pain	☐Loss of sense of smell	☐Frequent sore throats
	☐Dizziness	☐Hearing loss	☐Nosebleeds	☐History of head injury
	☐Ear discharge	☐Sinus infection	☐Nasal congestion	☐Fainting
Respiration	☐**None**	☐Cough	☐Shortness of breath	☐Wheezing
	☐Asthma	☐Coughing up blood	☐Sputum production	
Cardiovascular	☐**None**	☐Heart murmur	☐Palpitations/Arrythmia	☐Shortness of breath with exertion
	☐Claudication (leg pain and ache)	☐High blood pressure	☐Orthopnea (difficulty breathing lying down)	☐Varicose veins
		☐Low blood pressure		
Gastrointestinal	☐**None**	☐Belching	☐Difficulty swallowing	☐Jaundice
	☐Abdominal pain	☐Black/tarry stool	☐Heartburn	☐Ulcers
	☐Abnormal stool (color/consistency)	☐Constipation	☐Hemorrhoids	☐Rectal bleeding
		☐Diarrhea	☐Indigestion	☐Loss of bowel control
Female	☐**None/NA**	☐Breast lump/pain	☐Birth control	☐Urine retention/incontinence
	☐Abnormal vaginal bleeding	☐Burning with urination	☐Irregular menstruation	
		☐Frequent urination	☐Vaginal discharge	☐Cramps
	Pregnancy status:	☐Currently pregnant	☐NOT currently pregnant	
	Menses:	☐Currently have menses	☐Currently DO NOT have menses	
		☐Are regular	☐Are NOT regular	
	Date of last menstrual period: _____/_____/_____			
	If you have been pregnant in the past, please fill in the appropriate information below:			
	_____ Number of pregnancies		_____ Number of deliveries	
	_____ Number of vaginal deliveries		_____ Number of C-sections	
Male	☐**None/NA**	☐Burning with urination	☐Frequent urination	☐Urine (Retention/Incontinence)
	☐Erectile dysfunction	☐Hesitancy/dribbling	☐Prostate problems	
Sexual Health	Do you have any concerns about your sexual health? ☐Yes ☐No			
	Are you or have you ever been a victim of domestic or sexual abuse? ☐Yes ☐No			
Skin	☐**None**	☐Hair loss	☐Itching	☐Skin lesions/ulcers
	☐Change in nail texture	☐Hives	☐Numbness	☐Varicosities
	☐Change in skin color	☐Skin disorders	☐Rash	
Nervous System	☐**None**	☐Facial weakness	☐Loss of consciousness	☐Unsteadiness of gait/loss of balance
	☐Dizziness	☐Limb weakness	☐Seizures	
	☐Headache	☐Numbness	☐Stroke	☐Sleep disturbance
	☐Stress	☐Concussion	☐Slurred speech	
Psychological	☐**None**	☐Bi-polar disorder	☐Depression	☐Memory loss
	☐Anxiety	☐Confusion	☐Insomnia	☐Loss or change of appetite
	☐Behavioral change	☐Convulsions	☐Mood change	☐Panic attacks
Hematologic	☐**None**	☐Bleeding	☐Blood transfusion	☐Fatigue
	☐Anemia	☐Blood clotting	☐Bruising easily	☐Lymph node swelling

Please check the appropriate response. If you are not sure then check the "?" box.

No	Yes	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Your pain does NOT improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person > 50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history or prolonged user of corticosteroids?
☐	☐	☐	Acute onset of urinary tract retention or overflow incontinence (wet underwear)?
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
☐	☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)?

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Thiele Chiropractic & Wellness.

Patient (or Authorized Person) Signature Relationship to patient Date

Doctor's Signature Date Reviewed