PATIENT APPLICATION SURVEY

Name _____ Gender M F Age _____

Home Address _____ Home Phone _____

City, Province, Postal Code _____ Work Phone _____

Email Address _____ Cell Phone _____

Birth Date (MM/DD/YY) _____ / _____ / _____

Occupation _____

Emergency Contact _____ Phone _____

Primary care provider (chiropractor, medical physician, naturopath, etc) _____

Whom may we thank for referring you to our office? _____

PURPOSE OF THIS VISIT

Reason for this appointment – Main Complaint: _____

What was the cause? _____

Rate your pain on a scale of **1 to 10** with **zero** being no pain and **10** being the worst pain

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your symptoms? _____ Are your symptoms worse in the: AM PM

Is there anything, which has relieved your symptoms? Yes No Describe:_____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

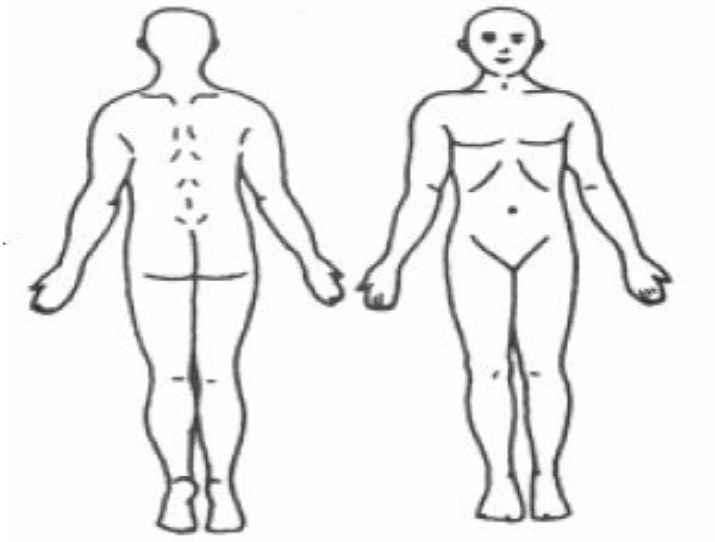
Does the Pain Radiate into your: Arm Leg No Is this condition getting worse? Yes No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Have you experienced this condition before? Yes No If so, please explain: _____

Who have you seen for this? What did they do? What did they do? _____

PLEASE MARK **on the diagram to the right** with the **following letters on the specific areas** to describe your symptoms: ***R** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** =Numbness **S** = Sharp/ Stabbing **T**= Tingling*



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

Any recreational drug use? □ Yes □ No How much? _____

Do you drink alcohol? □ Yes □ No How much per week? _____

Please list any allergies you may have: _____

Please list any medications currently taking and their purpose: _____

Please check if you are currently experiencing or have experienced any of the following conditions in the past:

□ Headaches	□ Contagious Disease	□ Dislocations/Subluxations	□ Eczema
□ Dizziness	□ Arthritis/osteoporosis	□ Shortness of Breath	□ Psoriasis
□ Fainting	□ High/Low Blood Pressure	□ Chest Pain	□ Digestion Trouble
□ Seizures/Convulsions	□ Painful Muscle Tension	□ Bruise Easily	□ Stomach Problems
□ Heart Disease	□ Muscle Cramps	□ Varicose Veins	□ Anxiety
□ Depression	□ Kidney Disease	□ Skin Infection	□ Communicable Skin Infection
□ Frequently Tired	□ Hemophilia	□ Herniation	

WOMEN

□ Frequent Menstrual Cramping

□ Pelvic Inflammation/Infection

Are you pregnant? □Yes □ No, If YES, how many months/weeks? _____

MEN

□ Prostate/Urinary Infection

I understand that the personal information provided will be kept confidential and secure and only used by the therapist and administrative personnel of Focus Chiropractic to further any treatment I receive.

I understand why the personal medication information which I am providing is needed by Focus Chiropractic and I authorize them to keep this information on file to be used as necessary.

I have had the opportunity to ask questions and understand and agree that Focus Chiropractic and its therapists are not responsible for any unforeseen medical complications. I understand that sometimes pain and discomfort may be felt after any manual therapy is performed. I agree to exercise my judgement during treatment and will inform the practitioner of any changes or concerns I may have. I agree to waive my right to hold Focus Chiropractic and practitioners/therapists to any claim of liability.

24-hour notice of cancelation is required or a fee will be charged.

Patient Signature (if under 18, signature of parent or guardian): _____

Office Use Only

Referral _____

Walk In

ID _____

Assignment _____