

CONFIDENTIAL PATIENT INFORMATION



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573-636-6400

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Columbia, MO 65202  
573-514-7796

www.SpinalRejuv.com

\_\_\_\_\_  
Patient Name (Please Print)

## PATIENT APPLICATION FORM

Welcome to our clinic! We specialize in helping our patients achieve their highest level of health through corrective care programs. Our techniques correct the condition and posture of the spine as well as associated musculoskeletal conditions that also affect quality of life. Our unique approach offers advances beyond other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Although we focus on corrective care programs, we realize that your condition and circumstance are unique. We value and trust your decisions regarding the care you seek. We are committed and concerned about your health and would like to know your expectations regarding care.

**Please check the box that best describes the type of care you are looking for at this time.**

- I am only interested in a health consultation in order to find out whether rehabilitative care may help; I do not want care for my condition at this time.
- I am only interested in symptomatic care and pain relief.
- I am interested in corrective care as a long term solution to my health problems.

Please fill out the following questionnaire accurately and completely so that the doctor can thoroughly evaluate your case. The doctor will use this information you provide as well as your examination and x-rays (if required) to determine whether you are a candidate for our rehabilitative programs. Please feel free to ask questions if you need assistance. We look forward to serving you!

\_\_\_\_\_  
Patient Signature                      / /                      / /  
DOB:    Date

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Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status: S M D W SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

If Patient is Minor, Parent/guardian's Names: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell/Work Phone: ( ) \_\_\_\_\_

Names of Children and ages: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

Do you have Health Insurance:  Yes  No Type of Insurance:  Commercial/Private  Medicare  Medicaid

**(Please allow our staff to photocopy your driver's license and insurance card)**

**Complete below ONLY if different from above and/or not included on your Insurance Card**

Patient's Relationship to Primary Insured /Party Responsible for Billing:  Self  Spouse  Child/dependent  Other: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Gender: M F Marital Status: S M D W

Insured's Address: \_\_\_\_\_ Insured's Home Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Insured's Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Insured's Cell Phone: ( ) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**PLEASE NOTE THAT YOUR NAME & DATE IS REQUIRED AT THE TOP OF EACH PAGE. THANK YOU.**

By signing below, I affirm that the above information is accurate and true:

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Patient Name: \_\_\_\_\_

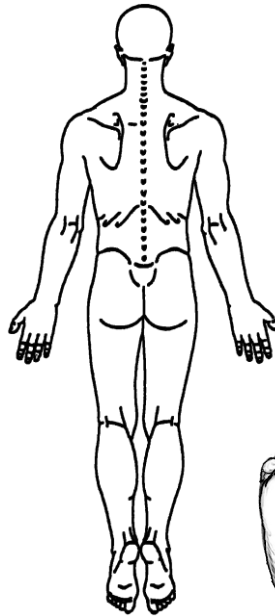
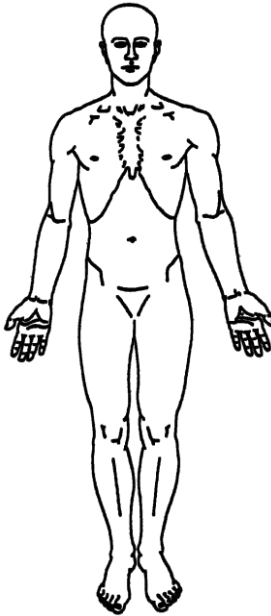
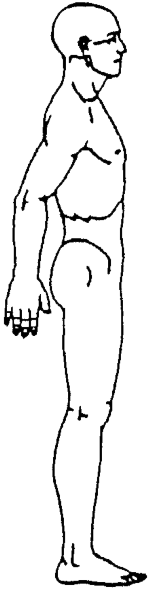
Date: \_\_\_\_\_

Main Complaint(s): \_\_\_\_\_

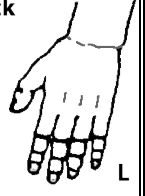
**Circle the area(s) causing you pain on the drawings below and label each area by the type of pain.**

RIGHT SIDE

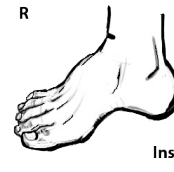
LEFT SIDE



Palm



Back



Inside of Feet

When did symptoms or condition begin? \_\_\_\_\_

How did it begin: \_\_\_\_\_

Is this complaint related to a trauma, accident or injury?  Yes  No If yes, describe: \_\_\_\_\_

Have you experienced this condition before?  Yes  No If yes, describe & when \_\_\_\_\_

Has this condition become worse recently?  Yes  No If yes, how has it worsened:  Gradually Worse  Abruptly Worse  Erratic

If no, has it:  Remained the Same  Improved  Other: \_\_\_\_\_

What aggravates your complaint(s)? \_\_\_\_\_

What relieves or improves your complaint(s)? \_\_\_\_\_

What have you tried to improve your complaint(s) that did not help? \_\_\_\_\_

Describe your Pain (check all that apply):  Sharp  Dull  Ache  Burning  Throbbing  Spasm  Numbness  Tingling  Shooting

Sore  Other: \_\_\_\_\_

**Doctors Notes – Office Use Only**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Patient Name:

Date:

Please rate your level of pain on a scale of 0 to 10, with 0 = no pain and 10 = most severe / worse pain you have ever experienced.

Circle the number below; if you have more than one area of complaint please identify each area.

My Current Pain is: 0 1 2 3 4 5 6 7 8 9 10

My Average Pain is: 0 1 2 3 4 5 6 7 8 9 10

My Pain at Best is: 0 1 2 3 4 5 6 7 8 9 10

My Pain at Worst is: 0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate or travel? Yes No If yes, where does the pain travel or radiate? Describe:

How often does your complaint(s) affect you? Daily 4-6X's/Week 2-3X's/Week 1X/Week other:

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

What Activities of Daily Living are affected by your symptoms/complaint(s): (Check ALL that apply)

- Almost all activities, My Daily Routine, Standing, Standing for long periods, Sitting, Sitting for long periods, Going from Sitting or Lying to Standing, Changing Positions, Lying Down, Walking, Running, Lifting, Bending Over, Getting out of Bed in morning, Daily Personal Care, Work Duties, Driving, Sleeping, Hobbies, Recreation/Sports Activities, Concentrating, Computer Work, Daily Household Chores, Getting Dressed, Going Up/Down Stairs, Reading, Social Activities;

Please explain or list others:

Are your symptoms Worse: in the morning in the afternoon in the evening no change through-out day other:

Are your symptoms Better: in the morning in the afternoon in the evening no change through-out day other:

Are you currently under medical or chiropractic care for this complaint(s)? Yes No

If yes, Who have you seen for this complaint?

What did they do? How did you respond?

Are you currently under medical care for any other health condition? Yes No If yes, explain:

Have you had any changes in bodily functions since the condition began? Yes No If yes, please check all that apply:

- Balance, Coordination, Gait, Bowel Habits, Urination, Menstrual, Breathing, Coughing, Sneezing, Vision, Hearing, Sexual Function, Weakness, Fatigue, Temperature, Grip Strength, Weight Loss, Weight Gain

Do you have any other complaints or concerns with your health?

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Blank lines for doctor notes.

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Date: \_\_\_\_\_

**EXPERIENCE WITH CHIROPRACTIC**

Have you ever received chiropractic care before?  Yes  No If yes, with whom? \_\_\_\_\_  
Date of last visit \_\_\_\_\_ For how long were you receiving care? \_\_\_\_\_  
How frequent were your visits \_\_\_\_\_ Reason for visits: \_\_\_\_\_  
How did you respond? \_\_\_\_\_ Reason for ending care: \_\_\_\_\_  
Are you aware of any of your poor posture habits?  Yes  No Explain: \_\_\_\_\_

**SOCIAL HISTORY – HEALTHY LIFESTYLE**

In general, would you say your health is:  Excellent  Very Good  Good  Fair  Poor  Other: \_\_\_\_\_

Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago  About the same  Much worse than one year ago
- Somewhat better now than one year ago  Somewhat worse than one year ago

Where do you consider your health?  Highest Priority  High Priority  Average Priority  Low Priority  Haven't thought about it.

Do you exercise?  Yes  No How often per week? \_\_\_\_\_

What activities?  Walking  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other: \_\_\_\_\_

What is your current height and weight? Height: \_\_\_\_\_ ft \_\_\_\_\_ inches Weight: \_\_\_\_\_ lbs

Do you smoke?  Yes  No How much?  1-5 cig/day  6-10 cig/day  1 pack/day  > 1 pack/day: \_\_\_\_\_

Do you drink alcohol?  Yes  No How much / week on average? \_\_\_\_\_

Do you drink coffee/caffeinated drinks?  Yes  No How many cups / day? \_\_\_\_\_

Do you currently have a drug or substance abuse problem?  Yes  No If yes, discuss with doctor.

Please describe your Work: \_\_\_\_\_

Type:  Professional  Physical Labor  Driver  Clerical  Factory  Homemaker  Other: \_\_\_\_\_

Physical Demands:  Heavy  Moderate  Mild  Sedentary Stress Level:  High  Medium  Low

Do you currently take any prescription or non-prescription drugs or supplements, i.e. vitamins, minerals, herbs? Please list below:

Name	Reason for taking	Name	Reason for taking

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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FAMILY MEDICAL HISTORY

Please note any family history: M = Mother, F = Father, S = Sibling, ♀GP = Maternal Grandparent, ♂GP = Paternal Grandparent

- Cancer: M F S ♀GP ♂GP
Diabetes: M F S ♀GP ♂GP
High Blood Pressure: M F S ♀GP ♂GP
Heart Disease: M F S ♀GP ♂GP
Arthritis: M F S ♀GP ♂GP
Stroke: M F S ♀GP ♂GP
Headaches: M F S ♀GP ♂GP
Spine or Back Disorders: M F S ♀GP ♂GP
Multiple Sclerosis: M F S ♀GP ♂GP
Psychological Disorders: M F S ♀GP ♂GP

Are there any other diseases or conditions that are common among your family members, i.e. inherited diseases or conditions? Yes No

Describe:

REVIEW OF SYSTEMS

Please identify any area of the body that you have any condition or problem with, past or present:

- Skin, hair or nail
Mouth and/or throat
Nose and/or sinus
Ear(s)
Eye(s)
Chest or lung (breathing)
Heart and/or blood vessel
Blood or lymph node
Digestive System
Urinary (including kidney or bladder)
Nervous system diseases
Mental health Conditions
Gland and/or hormone
Allergy or Immunity
Muscle, Tendon or Ligament
Bone (ex: osteoporosis)
Joint(s) (ex: arthritis)
Genital (e.g. prostate, testicular, vaginal, uterus)
Females only
Do you have menstrual problems?
Have you ever taken birth control pills?
Currently taking?
Do you have any breast problems?
Are you or is there a possibility you are pregnant?

Please explain:

PAST MEDICAL HISTORY

List any diseases that you have had in the past, including childhood diseases (example: Chickenpox):

List any conditions you been diagnosed with: (examples: Diabetes, Cancer, AIDS, Cardiovascular Disease, etc):

List ALL past physical injuries: (examples: falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, strains, dislocations, broken or cracked bones, etc.):

List all past surgeries or operations you have had: (don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy):

- 1. date: 5. date:
2. date: 6. date:
3. date: 7. date:
4. date: 8. date:

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