3237 W. Truman Blvd, Ste 101
Jefferson City, MO 65109
573-636-6400

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

CONFIDENTIAL PATIENT INFORMATION

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'sWork 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:

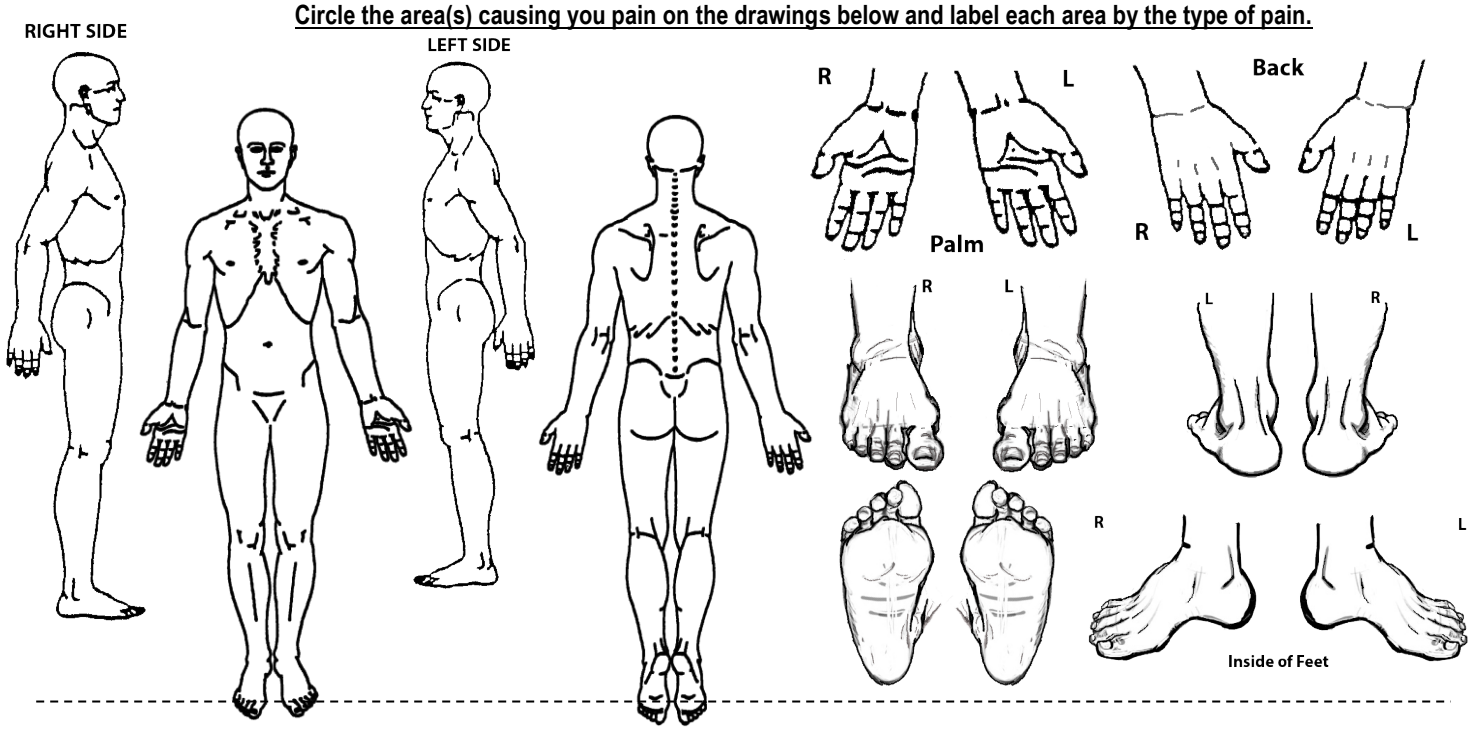
Patient Signature: _____ ***Date:*** _____

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.



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 is 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

_____

_____

_____

CONFIDENTIAL PATIENT INFORMATION

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 <u>more than one area of complaint please identify each area.</u>

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	☐ Walking	☐ Hobbies
☐ My Daily Routine	☐ Running	☐ Recreation/Sports Activities
☐ Standing	☐ Lifting	☐ Concentrating
☐ Standing for long periods	☐ Bending Over	☐ Computer Work
☐ Sitting	☐ Getting out of Bed in morning	☐ Daily Household Chores
☐ Sitting for long periods	☐ Daily Personal Care	☐ Getting Dressed
☐ Going from Sitting or Lying to Standing	☐ Work Duties	☐ Going Up/Down Stairs
☐ Changing Positions	☐ Driving	☐ Reading
☐ Lying Down	☐ Sleeping	☐ 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	☐ Bowel Habits	☐ Breathing	☐ Vision	☐ Weakness	☐ Grip Strength
☐ Coordination	☐ Urination	☐ Coughing	☐ Hearing	☐ Fatigue	☐ Weight Loss
☐ Gait	☐ Menstrual	☐ Sneezing	☐ Sexual Function	☐ Temperature	☐ Weight Gain

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

_____

Doctors Notes – Office Use Only

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_____

Patient Name: **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 anyprescription or non-prescription drugs or supplements, i.e. vitamins, minerals, herbs? Please list below:

Name	Reason for taking	Name	Reason for taking

Doctors Notes – Office Use Only

_____

_____

_____

_____

Patient Name: **Date:**

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? ☐ Yes ☐ No

Have you ever taken birth control pills? ☐ Yes ☐ No

Currently taking? ☐ Yes ☐ No How long: _____

Do you have any breast problems? ☐ Yes ☐ No

Are you or is there a possibility you are pregnant? ☐ Yes ☐ No

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:_____
2. _____ date:_____
3. _____ date:_____
4. _____ date:_____
5. _____ date:_____
6. _____ date:_____
7. _____ date:_____
8. _____ date:_____

Doctors Notes – Office Use Only

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