Angelo
Chiropractic & Acupuncture

Application for Treatment
Confidential Patient Information

Date: _____
Whom may we thank for referring you? _____
Name: _____ Email: _____
Cell Phone: _____ Home Phone: _____
Address: _____ Zip Code: _____
City: _____ State: _____ Age: _____ Date of Birth: _____
Height: _____ Weight: _____ Marital Status: M W S D Number of Children: _____
Occupation: _____ Employed by: _____
Spouse Name: _____ Phone Number: _____
Contact in Case of Emergency: _____ Phone number: _____

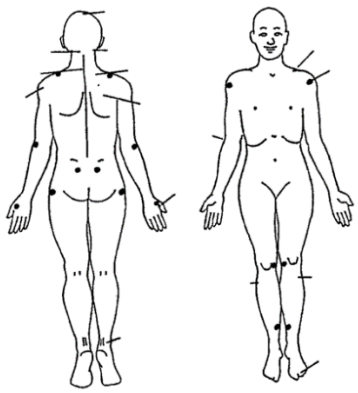
Reason(s) for Visit:_____
_____
_____

On a scale of **1** to **10** with **10** being the worst pain and zero being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Secondary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How long does it last? ☐ Constant ☐ On & Off During the Day ☐ Comes & Goes Throughout the Week

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



When did it first appear? _____
Have you had this condition previously? _____
Is this condition getting progressively worse? Yes No
Does your condition interfere with (circle all that apply): Work Sleep Bending Reaching
Digestion Menstruation Mental Status Bowel/Bladder Function Sex Drive

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Have you been treated by any physician/health provider for this condition?_____
Are you allergic to any medications or foods?_____
Are you taking medications, supplements or vitamins? _____
Surgeries? _____
How would you rate your overall health?

Worst you have ever been ——————————— Best you have ever been

Smoking: ☐Cigars ☐E-Cigarette ☐Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
Alcoholic Beverage: Consumption Occurs? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
Exercise / Recreational Activities: ☐ Daily ☐ 3+ Weekly ☐ 1x Weekly ☐ Never
Caffeine drinks (per day/week)? _____

Review of Systems: (Please mark/circle all that are applicable)

Neurological
- ☐ Allergies
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Nervousness
- ☐ Numbness
- ☐ Loss of Sleep
- ☐ Pins & Needles

Digestive
- ☐ Excessive Gas
- ☐ Colon Problems/IBS
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Gall Bladder/Liver Trouble
- ☐ Anorexia/Bulimia
- ☐ Ulcers

Eyes, Ears, Nose & Throat
- ☐ Ear Infection
- ☐ Eye Infection
- ☐ Sore Throat
- ☐ Sinus Infection
- ☐ Tonsillitis
- ☐ Ringing in ears
- ☐ Hearing Loss
- ☐ Swelling of Ankles

Muscle & Joint
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot/Ankle Pain
- ☐ Hip Disorders
- ☐ Knee Pain
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ TMJ Disorder
- ☐ Low Back Pain

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rapid Heartbeats
- ☐ High Cholesterol
- ☐ Pain Over Heart
- ☐ Poor Circulation
- ☐ Excessive Bruising
- ☐ Swelling of Ankles
- ☐ Abnormal Heartbeat
- ☐ Varicose Veins

Respiratory
- ☐ Asthma
- ☐ Apnea
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Chronic Cough

Genitourinary
- ☐ Bedwetting
- ☐ Infertility
- ☐ Kidney Infection
- ☐ Erectile Dysfunction
- ☐ Prostate Issues

Skin
- ☐ Acne
- ☐ Dryness
- ☐ Eczema
- ☐ Rash
- ☐ Yeast/Fungus

Constitutional
- ☐ Fainting
- ☐ Fatigue
- ☐ Low Libido
- ☐ Poor Appetite
- ☐ Weakness

Female
- ☐ Heavy Flow
- ☐ Heavy Cycle
- ☐ Painful Cycle
- ☐ Discharge
- ☐ Menopausal Yes No

Other

☐ Acid Reflux	☐ AIDS	☐ Anemia	☐ Alcoholism	☐ Arnold Chiari
☐ Autism	☐ ADHD	☐ Cancer	☐ Diabetes	☐ Epilepsy
☐ Fibromyalgia	☐ Gout	☐ Glaucoma	☐ Heart Disease	☐ Multiple Sclerosis
☐ Herniated Disc	☐ Hepatitis	☐ Migraines	☐ Spine Degeneration	☐ Rheumatoid Arthritis

☐ Other: _____

Your Goals For Care:

☐ Feel better quickly/pain relief	☐ Feel better and prevent its return
☐ Have a healthier spine/nervous system	☐ I want optimum health and to live a healthier lifestyle

Patient Agreement

Our Policy requires payment in full for all services at the time of service, unless other arrangements have been made with our office. Insurance must be verified before acceptance for payment. Any services not covered by insurance is due within thirty days.

Signature of Patient, Parent, or Guardian: _____
Date: _____

Please be courteous and silence/turn off cell phones. We ask that you please arrive promptly to your appointment, all arrivals 10 minutes after appointment time will be rescheduled.

Thank you for allowing us to help with your health!