Elevation Health Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

Section 1: Patient Information

Appt. Date: _____ **Referred *By:*** _____

Name (first, middle, last):_____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: ___/__/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Social Security Number: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employer: _____ Occupation: _____ Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children: _____

Emergency Contact: _____ Relationship_____ Phone # (____) _____

Section 2: History of Complaint

Primary Complaint(s): _____

Secondary Complaint(s): _____

Are your complaints due to an Accident? ☐ YES ☐ NO If yes, what type? ☐Work ☐Auto ☐ Personal

Date of Accident_____ If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No

Who was it reported To? _____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

_____

List any medications you currently take. (Prescription and non-prescription)_____

_____

_____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ❑ No ❑ Yes

If yes whom & what condition(s): _____

_____

Section 4: Chiropractic History

Have you ever seen a Chiropractor before? ☐ Yes ☐ No When _____/_____/_____

For what reason were you seen?_____ Were you helped? ☐ YES ☐ NO

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 5: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end** **10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐Lt ☐Rt

Date:___/__/_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries:_____ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: **1-1-2008** ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice & bruised Left Elbow**

Date:___/__ /_____ Type of Injury:_____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

D. Repetitive Injuries (Please list **all** repetitive injuries you've had in the past.)

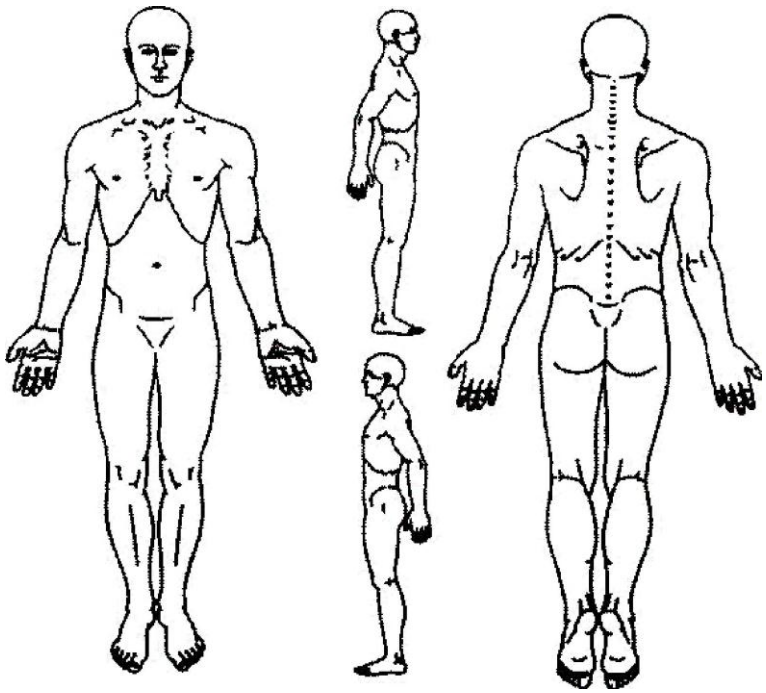
Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/__ /_____ Type of Injury: _____ ☐ Lt☐Rt

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 6: Present and Past Conditions

Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R & L*** .

P = **P**ast Health Issue **C** = **C**urrent Health Issue **N** = **N**ever had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities	Location	tory	Other Conditions	Male
___ Hip ☐ Pain ☐ Stiff	☐ R ☐ L	___ Asthma	___ Headaches / Migraines	___ Impotence
___ Knee ☐ Pain ☐ Stiff	☐ R ☐ L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Foot ☐ Pain ☐ Stiff	☐ R ☐ L	___ Difficulty Breathing	___ Excessive Sweating	**Female**
___ Shoulder ☐ Pain ☐ Stiff	☐ R ☐ L	___ Lung Problems	___ Cancer & Type: _____	___ Menopausal Problem
___ Elbow ☐ Pain ☐ Stiff	☐ R ☐ L	___ COPD	___ Emotional / Mental Disorders	___ Menstrual Cycle Problems
		Digestion	___ Learning Disability	
___ Wrist ☐ Pain ☐ Stiff	☐ R ☐ L	___ Heartburn	___ Nervous / Irritable	
___ Jaw Pain ☐ Click ☐ Pop	☐ R ☐ L	___ Digestion Problems	___ Loss of Memory	**Social History**
___ Swollen or Painful Joints		___ Gallbladder Problems	___ Dizziness / Loss of Balance	____ Smoking How much _____ How Often _____
Spine		___ Colon Trouble	___ Arthritis	
___ Head / Shoulders Feel Heavy / Tired		___ Diarrhea / Constipation	___ Epilepsy / Convulsions	
___ Neck ☐ Pain ☐ Stiff	☐ R ☐ L	___ Hemorrhoids	___ Knocked Unconscious	____ Alcoholic Beverage Consumption Occurs_____
___ Upper Back ☐ Pain ☐ Stiff	☐ R ☐ L	**Immune System**	___ Frequent Ear Infections	
___ Mid Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Skin Problems	___ Ringing in Ear R / L	
___ Low Back ☐ Pain ☐ Stiff	☐ R ☐ L	___ Sinus Problems/ Allergies	___ Hearing Loss R / L	____Recreational Drugs What Used_____ How Often_____
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:_____		___ Frequent Colds / Flu	___ Trouble Concentrating	
		___ Anemia	___ AIDS / HIV	
Other:_____		___ Other: _____	___ Fracture / Dislocation of Bones: _____	____Exercise Type_____ How Often_____
		Organ Problems or Dysfunction	___Other: _____	
Numbness / Tingling or Pain In:		___ Diabetes	**Urinary Tract**	
___ Arm	☐ R ☐ L	___ Liver Trouble	___ Kidney Trouble	
___ Hand /Fingers	☐ R ☐ L	___ Hepatitis	___ Frequent Urination	
___ Legs	☐ R ☐ L	___ High/Low Blood Pressure	___ Bedwetting	
___ Foot / Toes	☐ R ☐ L	___ Heart	___ Other:_____	

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Patient Name _____ **DOB:**_____

Section 7: Functional Assessment: Check any activities of life that your current conditions are affecting:

- ☐ Sitting
- ☐ Sit to Stand
- ☐ Standing
- ☐ Walking
- ☐ Driving
- ☐ Sleep/Rolling
- ☐ Reading
- ☐ Computer Use
- ☐ Yard work/Gardening
- ☐ Running
- ☐ Climbing
- ☐ Pushing/Pulling
- ☐ Dressing/Shaving
- ☐ Dishes/Laundry
- ☐ Bending
- ☐ Lifting
- ☐ Exercising/Sports

Doctors Notes: _____

_____

Section 8: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: ***when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain)*** **.**

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident_____ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

List any past hospitalizations and/or surgeries:

Surgeries: _____

List Hospitalizations Other Than Surgeries: _____

Patient/Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

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