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: _____/_____/__________

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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.)

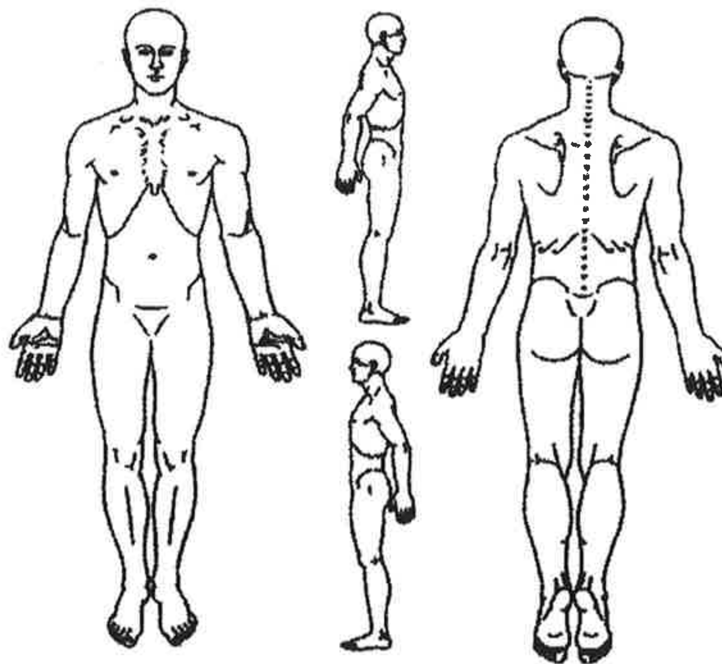
Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

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 = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling



Patient/Guardian's Signature: ______________________________ Date: ____/_____/________

Doctor's Signature ______________________________ Date Form Reviewed: ____/_____/________

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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 = Past Health Issue **C** = Current Health Issue **N** = Never 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	
Spine		___ Colon Trouble	___ Arthritis	____ Smoking How much __________ How Often __________
___ Head / Shoulders Feel Heavy / Tired		___ Diarrhea / Constipation	___ Epilepsy / Convulsions	
___ Neck ☐ Pain ☐ Stiff	☐ R ☐ L	___ Hemorrhoids	___ Knocked Unconscious	
___ Upper Back ☐ Pain ☐ Stiff	☐ R ☐ L	**Immune System**	___ Frequent Ear Infections	____ Alcoholic Beverage Consumption Occurs__________
___ 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	
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:__________		___ Frequent Colds / Flu	___ Trouble Concentrating	____Recreational Drugs What Used__________ How Often__________
		___ 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: ____/____/________

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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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Patient Name ______________________________ **DOB:**________________

Section 9: Awareness of Chiropractic Principles: *Were you aware that...*

Doctors of Chiropractic work with the nervous system?	☐ Yes ☐ No
The nervous system controls all bodily functions and systems?	☐ Yes ☐ No
Chiropractic is the largest natural healing profession in the world?	☐ Yes ☐ No
If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐ Yes ☐ No

Doctors Notes: ____

____

Section 10: Goals for my Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desires so that we may be guided by your wishes whenever possible.

Relief Care: Symptomatic relief of pain or discomfort	☐ Yes
Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms	☐ Yes
Comprehensive Care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.	☐ Yes

What aggravates the problem?

What relieves the problem?

If this problem went without being taken care of, how do you think it would affect you?

Patient/Guardian's Signature: ______________________________ Date: ____/____/________

Doctor's Signature ______________________________ Date Form Reviewed: ____/____/________

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BASIC NUTRITION QUESTIONNAIRE

- * Have you ever been told you have High Cholesterol or Triglycerides? Yes / No
- * Have you ever been diagnosed with High Blood Pressure? Yes / No
- * Have you been Diagnosed as Diabetic? Yes / No
- * Have you been diagnosed as Pre-Diabetic or Metabolic Syndrome? Yes / No
- * How many days a week do you skip a meal? (3/meals/day) ______
- * How many "fast food", "refined food", or "pre-prepared" meals do you eat per week?

(0) (1-3) (4-6) (7 +)

* How many servings of fruit do you eat per day?

(0-1) (2-3) (4-5)

* How many servings of vegetables do you eat per day?

(0-1) (2-3) (4-5)

* Do you regularly drink one or more per day of the following: (circle all that apply)

Soda Diet Soda Coffee Juice Milk Alcohol

* How many servings of refined sugar do you eat per day? (Candy, Cookies, Cake, etc.)

(0-1) (2-3) (4-5)

* Please list all nutritional supplements/vitamins you take regularly:
(Staff can photocopy a list if you have one)

Supplement Name/Type	Frequency	Brand or Where Purchased