MESA CHIROPRACTIC REHAB & WELLNESS

Mesa Chiropractic Rehab & Wellness Patient Application

WELCOME TO OUR OFFICE

(Please print in **BLUE** or **BLACK** ink. If anything does not apply to you please put **N/A** on the line.)

Section 1: Patient Information

Full Name:_____

Preferred Name:_____ ▢ Male ▢ Female Date of Birth____/____/____

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

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

Employer:_____ Occupation:_____

SSN (last 4):_____ Email:_____

Marital Status: ▢ Married ▢ Single ▢ Divorced ▢ Widow Women Only: Are you Pregnant? ▢ Yes ▢ No

Spouse (Parent if patient is under 18) _____ Spouse's (or Parent's) Date of Birth____/____/____

Emergency Contact:_____ Relationship:_____ Phone: (____)_____

Section 2: Current Health Condition

Primary Complaint:_____

When did your symptoms appear?_____

Has it ever occurred before? ▢ Yes ▢ No

Was it due to an accident? ▢ Yes ▢ No

If yes, what type? ▢ Auto ▢ Work ▢ Personal

Rate the severity of your pain on a scale of

1 (least pain) to 10 (severe pain) _____

Have you seen any other doctors for this? ▢ Yes ▢ No

If yes, please list doctors name and treatment if any___

_____

Is this pain? ▢ Constant (100-75%) ▢ Frequent (75-50%)

▢ Intermittent (50-25%) ▢ Occasional (25-1%)

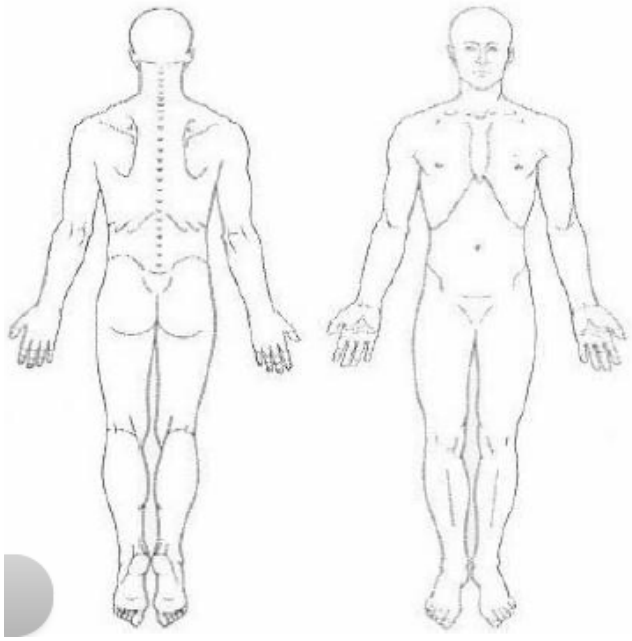
Is this condition getting ▢ Better ▢ Worse or is it staying the ▢ Same?

Is this condition worse in the ▢ AM ▢ PM or ▢ Same?

Second Complaint:_____

Third Complaint:_____

Please mark the areas on the **Diagram** with the following **letters** to describe your symptoms:
A=Aching **B=B**urning **D=D**ull **N=N**umbness
R=Radiating **S=S**harp/**S**tabbing **T=T**ingling



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

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Section 3: Functional Assessment

Please **Circle One** answer that best indicates the impact of your current condition on your ability to perform each of the following activities. If the activity does not pertain to you, please place an 'X' in the column marked "N/A".

* "Normal" is what you are accustomed to on a daily basis.

0=Normal Function **1**=Minimally Difficult **2**=Moderately Difficult **3**=Very Difficult **4**=Unable to Perform

ACTIVITY	SCORE					N/A
Sleep Normally	0	1	2	3	4	
Grooming (Ex. combing hair, shaving, etc)	0	1	2	3	4	
Getting dressed	0	1	2	3	4	
Food prep / Cooking / Eating	0	1	2	3	4	
Sitting for a normal* amount of time	0	1	2	3	4	
Standing for a normal* amount of time	0	1	2	3	4	
Walking	0	1	2	3	4	
Running / Jogging	0	1	2	3	4	
Going up and down stairs	0	1	2	3	4	
Recreational / Sports activities	0	1	2	3	4	
Reaching above the head or across the body	0	1	2	3	4	
Squatting down to pick up an item	0	1	2	3	4	
Lifting / Carrying up to 10 lbs.	0	1	2	3	4	
Getting up / down from sitting or laying down	0	1	2	3	4	
Driving	0	1	2	3	4	
Performing all job requirements at work	0	1	2	3	4	

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Section 4: Medical History

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

C = Current Health Condition **P = Past Health Condition** **N = Never had this Health Condition**

___AIDS/HIV	___Chemical Depend.	___Hernia	___Pacemaker
___Alcoholism	___Chest Pain	___Herniated Disk	___Parkinson's
___Allergies	___COPD	___High Blood Pressure	___Pinched Nerve
___Anemia	___Diabetes	___Kidney Disease	___Pneumonia
___Anxiety/Depression	___Digestion Problems	___Liver Disease	___Prostate Problems
___Appendicitis	___Dizziness/Vertigo	___Memory Problems	___Psychiatric Care
___Arthritis	___Eating Disorder	___Menstrual Problems	___Skin Problems
___Asthma	___Emphysema	___Migraines	___Sleeping Problems
___Autoimmune Dis.	___Epilepsy/Seizures	___Mononucleosis	___STD
___Back Pain	___Fatigue	___Multiple Sclerosis	___Stroke
___Bleeding Disorder	___Headaches	___Neck Pain	___Thyroid Disease
___Bronchitis	___Heart Disease	___Numbness/Tingling	___Tumors/Growths
___Cancer	___Hepatitis	___Osteoporosis	___Ulcers

Please list any other complaints / conditions you currently have or have had in the past_____

_____

Please list all broken bones / injuries / surgeries you have had and the date they occurred_____

_____

Is there anything else the doctor should know? ▢ Yes ▢ No If yes, please describe_____

_____

Section 5: Family History

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

If yes, whom and what condition(s)_____

_____

Section 6: Medications	Vitamins/Supplements	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Section 7: Chiropractic History

Have you ever seen a Chiropractor before? ▢ Yes ▢ No Date of most recent visit_____

For what reason were you seen?_____ Were you helped? ▢ Yes ▢ No

Section 8: Goals For Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. Thank you.

▢ I want the Doctor to select the type of care appropriate for my condition(s).

▢ Relief Care: Symptomatic relief of pain or discomfort

▢ Corrective Care: Correcting and relieving the cause of the problem as well as the symptom(s).

Section 9: Our Commitment to You

We are committed to giving you the best care possible in our office. If there is ever anything you wish to talk to the doctor about whether it be a question, concern or how we may better help you, please let one of us know. We are here to serve you and we are grateful for the opportunity.

Section 10: A Referral is the Greatest Compliment We Receive

Who may we thank for referring you to our office? _____

Section 11: Preferred Contact Number and Time

Please indicate your preferred contact number and time of day. Thank you.

Preferred Contact Number:_____

Preferred Time:_____

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