APPLICATION FOR TREATMENT

Personal Information

Name: _____Today's Date: _____/_____/_____

Address: _____City/State/Zip:_____

Email Address: _____ SS#: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Pregnant? Y N (N/A)

Employer's Name_____Occupation:_____

Who referred you to our office? _____

What level of care do you desire: Temporary Relief _____ Lasting Correction _____ Best Care Possible _____

In order of importance, list the health problems you are most interested in getting corrected.

1) _____

2) _____

3) _____

4) _____

In order of severity, list those body problems that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, etc

1)_____

2)_____

3)_____

When did you first notice this condition? _____

Frequency of pain? □ Constant (100% of the time) □ Occasional (<50% but 25% of the time)

□ Frequent (<75% but >50% of the time) □ Intermittent (less than 25% of the time)

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem _____

_____

Have you had any similar health problems or injuries before? ____ Yes ____ No If yes, please explain: _____

_____

Names of all other doctors you have seen for this problem: _____

Diagnosis and type of treatment you received (please include where and when you received treatment and the results):

_____

_____

Has your health problem been: ____Improving ____Worsening ____Staying the Same

Have you ever received Chiropractic care? ____Yes ____No If yes, please list name and location:_____

_____

Please list any known
allergies:_____

Are there any other accidents, operations or serious injuries (including broken bones) that the doctor should know?

_____

Have you been in an automobile accident? If so when?_____

Do you have any previous diagnostic imaging? □yes □no

If yes, what kind? _____

Social History

Do you use tobacco products? _____ If so, how much per week? _____

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you exercise? _____ If so, how many minutes per week? _____

Family History: **Place an (X) if any family member has suffered from:**

□Tuberculosis	□Kidney Disease	□Spinal Disorder	□Mental Illness	□Hypertension
□Diabetes	□Gout	□Allergy	□Arthritis	□Epilepsy
□Cancer	□Migraines	□Heart Attack	□Other, list: _____	

Personal History: **Place an (X) on any that apply:**

□ Single □ Married □ Divorced □ Separated □ Widow/Widower Employed Spouse? □Yes □No

Number of Children_____ Number of Children at home_____ Are you pregnant? □Yes □No □Not sure

Medications, describe_____

_____

Disease/Illness, describe _____

_____

Other, describe _____

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System Review: **Place an (X) you have suffered from:**

Musculoskeletal System

□ Arthritis
□ Back Problems
□ Cramping
□ Elbow/Wrist pain
□ Foot/Ankle pain Knee injuries
□ Fracture
□ Gout
□ Hip disorder
□ Implants or Plates
□ Joint or Muscle pains/stiffness
□ Knee injuries
□ Neck pain
□ Osteoporosis
□ Pins or Screws
□ Poor posture
□ Scoliosis
□ Shoulder problems
□ Swelling, Redness Deformity of Joints
□ TMJ issues

Nervous System

□ Anxiety and/or panic
□ Confusion
□ Depression
□ Difficulty concentrating
□ Dizziness
□ Epilepsy or seizures
□ Fainting
□ Forgetfulness
□ Paralysis
□ Loss of smell/taste
□ Muscle jerking
□ Numbness
□ Sleeping issues
□ Stroke
□ Weak Muscles

Head, Ears, Nose and Throat

□ Blurred or double vision
□ Cataracts
□ Changes in head dimensions
□ Chronic ear infections
□ Congestion
□ Dental problems
□ Difficulty swallowing
□ Ear or hearing problems
□ Ear ache
□ Eye or vision problems
□ Eye surgery
□ Glaucoma
□ Glasses or contacts
□ Gum problems
□ Headaches
□ Hoarseness
□ Migraines
□ Postnasal drip
□ Recent hearing loss
□ Ringing in the ear
□ Sinus trouble
□ Sore throat
□ Swollen Lymph nodes
□ TMJ problems

Cardiovascular System

□ Blood clots
□ Chest pain or tightness
□ Congenital heart defects
□ Coronary artery disease
□ High cholesterol
□ Leg pain upon walking
□ Lower extremity edema
□ Heart attack
□ Heart murmur
□ High blood pressure
□ Swollen legs or feet
□ Varicose veins
□ Palpitations
□ Rapid heartbeat
□ Rheumatic fever
□ Dyspnea

Respiratory

□ Apnea
□ Asthma
□ Blood in sputum
□ Emphysema
□ Hay fever
□ Persistent cough
□ Pneumonia
□ Shortness of breath
□ Snoring
□ Tuberculosis
□ Wheezing

Gastrointestinal System

□ Abdominal pain
□ Black stool
□ Bloating
□ Bloody stool
□ Changes in bowel habits
□ Colitis
□ Colon cancer
□ Colon polyps
□ Constipation
□ Crohn's disease
□ Diarrhea
□ Difficult chewing
□ Difficult swallowing
□ Excessive thirst
□ Food sensitivities
□ Gastric reflux
□ Gall bladder trouble
□ Heartburn
□ Hemorrhoids
□ IBS
□ Jaundice
□ Liver disease
□ Nausea
□ Pancreatitis
□ Poor appetite
□ Ulcer
□ Weight trouble
□ Vomiting

Genitourinary System

□ Blood in the urine
□ Incontinence
□ Kidney Stones
□ Painful or frequent urination
□ Sexual dysfunction
□ Urgency
□ Urinary infections

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Endocrine System

□ Cushing's syndrome
□ Diabetes
□ Excessive thirst
□ Feeling hot or cold all the time
□ Hyperparathyroidism
□ Hyperthyroidism
□ Increase size of hands or feet
□ Pancreatic conditions
□ Purple striae
□ Steroid treatments
□ Testosterone deficiency
□ Thyroid problems

Dermatological or Hematopoietic

□ Change in hair or nails
□ Easy bruising
□ Eczema
□ Excessive acne
□ Excessive hair loss
□ Flushing
□ Gum bleeding
□ Hyper/hypo pigmentation
□ Psoriasis
□ Skin cancer
□ Skin pigmentation issues
□ Skin trouble or rashes

ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section which most closely applies to you.

SECTION 1: PAIN INTENSITY

☐ I can tolerate the pain I have without using pain killers.
☐ The pain is bad but I manage without taking pain killers.
☐ Pain killers give complete relief from pain.
☐ Pain killers give moderate relief from pain.
☐ Pain killers give very little relief from pain.
☐ Pain killers give no relief from pain. I do not use them.

SECTION 2 : PERSONAL CARE

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in the most aspects of self care.
☐ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3: LIFTING

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (on a table).
☐ Pain prevents me from lifting heavy weights. I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4: WALKING

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than 1/2 mile.
☐ Pain prevents me from walking more than 1/4 mile.
☐ I can only walk using a cane or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5: SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than one hour.
☐ Pain prevents me from sitting for more than 30 minutes.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

SECTION 6: STANDING

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it causes extra pain.
☐ Pain prevents me from standing for more than one hour.
☐ Pain prevents me from standing for more than 30 minutes.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

SECTION 7: SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8: SEX LIFE

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9: SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10: TRAVELING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to the journeys of less than one hour.
- ☐ Pain restricts me to short necessary trips under a 1/2 hour.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

CURRENT CHIEF COMPLAINTS:

Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back ☐ Mid back ☐ Neck ☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L	☐ Arm R/L	☐ Elbow R/L
☐ Wrist R/L	☐ Forearm R/L	☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L	☐ Thigh R/L	☐ Knee R/L
☐ Leg R/L	☐ Ankle R/L	☐ Foot R/L

OTHER (describe): _____

_____

SUBJECTIVE PAIN LEVEL:

On a scale of 1 - 10, place an (X) in your current pain level

NORMAL EMERGENCY

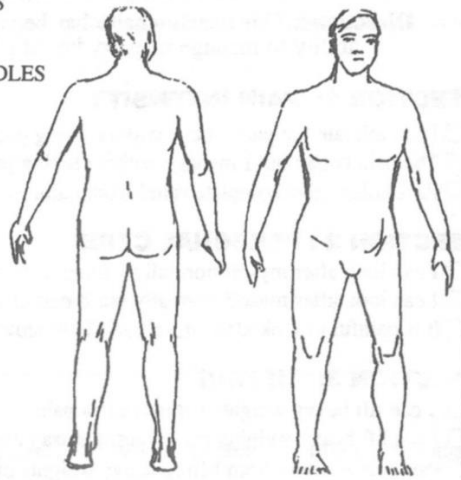
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

_____

Patient's Signature

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

× NUMBNESS
+ BURNING
○ PIN & NEEDLES
= STABBING



EXPAND PRODUCTS
1-800-548-3676

Form 004

Financial Responsibility

Your fees are due and payable at the time of examinations and treatments are received, unless other arrangements have been made in advance.

I the undersigned, hereby give permission for treatment.

Patient's Signature: _____ Date: _____

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to Dr. Roger Norris, all insurance

benefits, if any, otherwise payable to me for services rendered.

I understand that I am responsible for knowing my insurance benefits and I am financially responsible for my deductible and co-pay.

I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

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Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. Norris Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required by state law, for administrative purposes and to evaluate the quality of care that you receive.

Norris Chiropractic will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Norris Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those permitted under law.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

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