ACTIVELIFE FAMILY CHIROPRACTIC

13299 Summerfield Way
Pickerington, OH 43147

Lisa M. Jones, DC & John D. Jones, DC

Application for Treatment

Name _____ Date_____ SSN# _____

Street _____ City/State/Zip _____

Phone (H) _____ (W) _____ (Cell)_____ E-mail_____

Birth Date _____ Age _____ Referred By _____

Marital Status _____ Name of Spouse _____ No. of Children _____

Employer _____ Occupation _____

Emergency Contact Person _____Phone _____

Describe symptoms and **rate** them from
1 (very mild discomfort) to 10 (extremely painful).

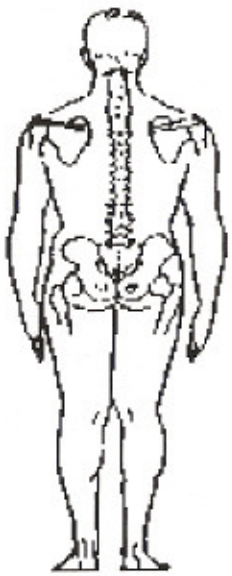
_____

_____

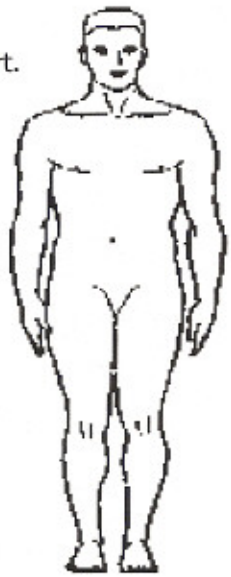
_____

_____

_____



Indicate areas of
current discomfort.



I feel (circle) Dull Pain Sharp Pain Burning Aching
Throbbing Tingling Numbness

Is your discomfort? (circle) Occasional Frequent Constant

Have you ever had this or a similar condition before? YES NO When? _____

What caused your **current** complaints?_____

_____

Describe how your condition affects your lifestyle/work/sleep_____

_____

How long have your **current** symptoms been present? _____

How are your symptoms changing? (circle) Getting Better Getting Worse Unchanged Coming and Going

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Describe any/all treatment you have already received for your **current** condition: _____

_____

_____

My condition affects my ability to: (circle) bend stand walk lift sit stand up drive climb stairs

get out of bed reach push/pull Other: _____

How did your symptoms begin? (circle) gradually suddenly

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

Are symptoms worse during? (circle) morning afternoon evening not applicable

Describe any past accidents/falls _____

_____

List any/all surgeries performed _____

_____

When not in pain, I typically exercise? (circle) Never Rarely Occasionally Regularly Intensely

Do you have a personal and/or family history of any of the following? (please circle all that apply)

Plaque in Arteries	NO	SELF	FAMILY	Diabetes	NO	SELF	FAMILY
Stroke	NO	SELF	FAMILY	Arthritis	NO	SELF	FAMILY
High Blood Pressure	NO	SELF	FAMILY	Cancer	NO	SELF	FAMILY
Heart Disease	NO	SELF	FAMILY	Scoliosis	NO	SELF	FAMILY

Smoking status: _____never a smoker _____former smoker _____current smoker

List any life threatening and/or medication allergies: _____

List current medications _____

_____

Have you ever seen a chiropractor before? (when/where/why/results) _____

_____

What is your current: Height _____ Weight _____

What was your most recent Blood Pressure Reading? _____

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Please check any of the following that apply to you:

- ☐ I am symptom free and here for wellness care
- ☐ Pain ☐ neck ☐ upper back ☐ mid back ☐ low back
- ☐ Stiffness ☐ neck ☐ upper back ☐ mid back ☐ low back
- ☐ Restricted motion ☐ neck ☐ low back
- ☐ Headache
- ☐ Pain in jaw ☐ left ☐ right
- ☐ Neck grating/popping
- ☐ Head seems too heavy
- ☐ Shoulders seem too heavy
- ☐ Restricted shoulder movement ☐ left ☐ right
- ☐ Pain in shoulder ☐ left ☐ right
- ☐ Pain down arm ☐ left ☐ right
- ☐ Pain in elbow ☐ left ☐ right
- ☐ Pain in wrist ☐ left ☐ right
- ☐ Pain in hand ☐ left ☐ right
- ☐ Tingling sensation in arm ☐ left ☐ right
- ☐ Tingling in fingers ☐ left ☐ right
- ☐ Restricted movement of hip ☐ left ☐ right
- ☐ Pain in hip ☐ left ☐ right
- ☐ Pain down leg ☐ left ☐ right
- ☐ Pain in knee ☐ left ☐ right
- ☐ Pain in ankle ☐ left ☐ right
- ☐ Pain in foot/toes ☐ left ☐ right
- ☐ Tingling sensation down leg ☐ left ☐ right
- ☐ Tingling in foot/toes ☐ left ☐ right

Recent onset of:

- ☐ Urinary tract infection
- ☐ Night cramps
- ☐ Abnormal hearing ☐ Abnormal speech
- ☐ Abnormal swallowing ☐ Abnormal taste
- ☐ Abnormal vision
- ☐ Convulsions ☐ Seizure disorders
- ☐ Incontinence
- ☐ Bowel dysfunction
- ☐ Loss of coordination ☐ Loss of balance
- ☐ Head trauma
- ☐ Memory lapses ☐ Disorientation
- ☐ Mood swings ☐ Emotional distress
- ☐ Fever
- ☐ Significant nutritional problem
- ☐ Significant weight loss ☐ Sig. weight gain
- ☐ Fainting spells
- ☐ Blurred vision
- ☐ Chest pain ☐ Shortness of breath
- ☐ Dizziness
- ☐ Ringing/buzzing in ears
- ☐ Double vision
- ☐ Loss of smell ☐ Loss of taste
- ☐ Insomnia
- ☐ Nausea ☐ Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Anxiety ☐ Fatigue
- ☐ Tension/stress ☐ Depression

Additional complaints _____

_____

Patient's Signature _____ Date _____

Welcome to our office! If at any time you have questions, comments, or concerns regarding any aspect of our office please feel free to express yourself. We look forward to sharing the benefits of chiropractic with you!