absolute CHIROPRACTIC

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

Patient name

_____

Date Completed

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Handphone: ( ) _____

Postcode: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ /_____ /_____ NRIC/FIN#: _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)? ◯ Yes ◯ No If yes, when: _____ /_____ /_____

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? _____ / _____ / _____ Are they: ◯ Constant ◯ Intermittent ◯ Activity-related

Are they getting worse? ◯ Yes ◯ No Do they interfere with: ◯ Work ◯ Sleep ◯ Hobbies ◯ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ◯ Yes ◯ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ◯ Yes ◯ No

If yes, explain: _____

Have you been treated for this? ◯ Yes ◯ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? ◯ Yes ◯ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? ◯ Yes ◯ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ◯ Yes ◯ No Did they recommend a Home Health Care program? ◯ Yes ◯ No

If yes, what? _____ How long were you treated? _____ Last treatment: _____/ _____ / _____

How did you respond? _____

Are you aware of any poor posture habits? ◯ Yes ◯ No Is there any history of spinal problems in your family? ◯ Yes ◯ No

If yes, explain: _____

_____

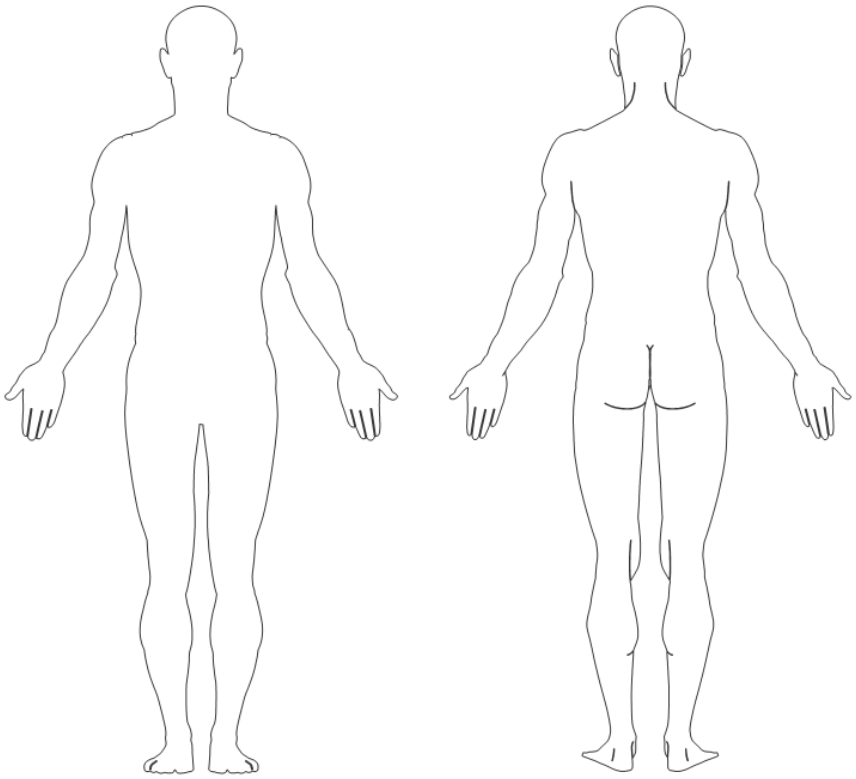
_____

_____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today

A = ACHE G = STABBING N = NUMBNESS B = BURNING M = SPASMS
F = STIFFNESS T = TINGLING P = PINS & NEEDLES O = OTHER



If you marked "O" on any part, please explain:

_____

_____

_____

Health & Lifestyle

Do you exercise? ◯ Yes ◯ No How often? _____ day(s) per week; Other: _____

What activities? ◯ Walking ◯ Running/Jogging ◯ Weight Training ◯ Cycling ◯ Yoga ◯ Pilates ◯ Swimming ◯ Other_____

Do you smoke? ◯ Yes ◯ No How much? / How often? _____

Do you drink alcohol? ◯ Yes ◯ No How much? / How often? _____

Do you drink coffee? ◯ Yes ◯ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

_____

_____

_____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain	____ Headaches	____ Sinusitis
____ Pain in shoulders/arms/hands	____ Dizziness	____ Allergies/Hay fever
____ Numbness/tingling in arms/hands	____ Visual disturbances	____ Recurrent colds/Flu
____ Hearing disturbances	____ Coldness in hands	____ Low Energy/Fatigue
____ Weakness in grip	____ Thyroid conditions	____ TMJ/Pain/Clicking

Please explain: _____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations	____ Recurrent Lung Infections/Bronchitis
____ Heart Murmurs	____ Asthma/Wheezing
____ Tachycardia	____ Shortness of Breath
____ Heart Attacks/Angina	____ Pain with Deep Inspiration/Expiration

Please explain: _____

_____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain	____ Nausea	____ Diabetes
____ Pain in Ribs/Chest	____ Ulcers/Gastritis	____ Hypoglycemia/Hyperglycemia
____ Indigestion/Heartburn	____ Reflux	

____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

_____

_____

1. *Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846*

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___ Pain in hips/legs/feet
___Weakness/injuries in hips/knees/ankles
___Low back pain
___Numbness/tingling in legs/feet
___ Recurrent bladder infections
___Coldness in legs/feet
___ Frequent/Difficulty urinating
___Muscle cramps in legs/feet
___Sexual dysfunction
___ Constipation/diarrhea
___Menstrual irregularities/cramping (females)

Please Explain

_____

_____

OTHER

Please list any health concerns not mentioned

_____

_____

Please list any medications you are taking and for how long you have been taking them for

_____

_____

Please list any surgeries you have had, and the approximate date

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes
____ Varicose Veins
____ Neurological Problems
____ Lung Disease
____ Rheumatic fever
____ Circulatory Problems
____ Stroke
____ Heart Murmur
____ High Blood Pressure
____ Heart Disease
____ Cancer
____ Osteoporosis
____ Kidney Disease
____ Paralysis
____ Migraine Headaches
____ Arthritis
____ Liver Disease
____ Metal Implants
____ Infectious Disease
____ Gall Bladder
____ Broken bones/fractures
____ Appendectomy
____ Tonsillectomy
____ Hernia
____ Pneumonia/Bronchitis
____ Polio
____ Tuberculosis
____ Anemia
____ Whooping Cough
____ Chicken Pox/Shingles
____ Mumps
____ Measles
____ Thyroid Problems
____ Small Pox
____ Influenza
____ Pleurisy
____ Blood Sugar Problems
____ Epilepsy/Seizures
____ Eczema/Psoriasis
____ Lumbago

___ Other:

_____

_____