

Patient Application

Please fill out the following information in its entirety to allow us the opportunity to better evaluate your case.
If you have any questions, please feel free to ask one of our assistants. Thanks!

Patient Information:

Name: _____ Preferred Name: _____ Date: ___ / ___ / ___

Male Female Birth Date: ___ / ___ / ___ SS#: ___ - ___ - ___

Marital Status: Single, Married, Divorced, Widowed, Other Anniversary Date: _____

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

Home Phone: _____ Work: _____ Cell: _____

May we call you at work when necessary? Yes No How many children do you have? _____

Email Address: _____ Religion (Optional): _____

Spouse: _____ Phone: _____

Mother: _____ State: _____ Phone: _____

Father: _____ State: _____ Phone: _____

Occupation: _____ Employer: _____

Referred to Office by: Friend/ Family _____, Yellow Pages, Mail, Location,

TV, Screening, Paper/ Article / Report, Radio, Internet, Other: _____

Payment for Services by (circle): Cash, Check, Credit Card, Health Insurance, Auto Insurance, Worker's Comp.

Type of Care Desired: Temporary Relief Lasting Correction

Insurance Information:

Ins. Company Name: _____ Phone: _____

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

Group # (Plan, Local, or Policy#): _____ I.D. #: _____

Subscribers Name: _____ Subscribers SS#: ___ - ___ - ___ Relation: _____

Date of Birth: ___ / ___ / ___ Employer: _____ Years Worked: _____

Health History:

Have You ever had any metal implants? Yes No

Have You ever been gun shot? Yes No

Have you been treated by a physician for any health condition in the last 12 months? Yes No

If Yes, please describe condition: _____

Surgical History:

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

Accident History:

- Job Auto Other: _____ **Date:** _____
- Job Auto Other: _____ **Date:** _____
- Job Auto Other: _____ **Date:** _____

Major Complaints or Symptoms: What are you hoping we can help you with? Please rate them on a scale of 1 – 10 with 10 as the worst.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> blurred vision _____ | <input type="checkbox"/> dizziness _____ | <input type="checkbox"/> loss of balance _____ | <input type="checkbox"/> ringing in ears _____ |
| <input type="checkbox"/> buzzing ears _____ | <input type="checkbox"/> face flushed _____ | <input type="checkbox"/> loss of smell _____ | <input type="checkbox"/> shortness of breath _____ |
| <input type="checkbox"/> cold feet _____ | <input type="checkbox"/> fainting _____ | <input type="checkbox"/> loss of taste _____ | <input type="checkbox"/> stiff neck _____ |
| <input type="checkbox"/> cold sweats _____ | <input type="checkbox"/> fatigue _____ | <input type="checkbox"/> low resistance to colds _____ | <input type="checkbox"/> stomach upset _____ |
| <input type="checkbox"/> concentration loss _____ | <input type="checkbox"/> fever _____ | <input type="checkbox"/> muscle jerking _____ | <input type="checkbox"/> None Present _____ |
| <input type="checkbox"/> confusion _____ | <input type="checkbox"/> head seems to heavy _____ | <input type="checkbox"/> numbness in fingers _____ | |
| <input type="checkbox"/> constipation _____ | <input type="checkbox"/> head aches _____ | <input type="checkbox"/> numbness in toes _____ | |
| <input type="checkbox"/> depression/weeping spells _____ | <input type="checkbox"/> insomnia _____ | <input type="checkbox"/> pins/needles in arms _____ | |
| <input type="checkbox"/> diarrhea _____ | <input type="checkbox"/> light bothers eyes _____ | <input type="checkbox"/> pins/needles in legs _____ | |

Please Write Down Any Additional Symptoms You May Be Experiencing:

_____ Rating: _____	_____ Rating: _____
_____ Rating: _____	_____ Rating: _____
_____ Rating: _____	_____ Rating: _____
_____ Rating: _____	_____ Rating: _____

More Vital Information: Please describe your “worst” symptom(s)

When and how did the complaints or symptoms begin/occur? _____

Symptoms developed from (please circle): job related, auto accident, illness, gradual onset or unknown cause

Symptoms have persisted for: _____ hour(s) _____ day(s) _____ week(s) _____ month(s) _____ year(s)

Symptoms Come and Go Are Constant Are Nearly Constant

Have you been treated by a medical physician for this condition before? Yes No

-If yes, where and by whom? _____

Are you taking any medications? Yes No If yes, what? _____

Are you allergic to any medications? Yes No If yes, what? _____

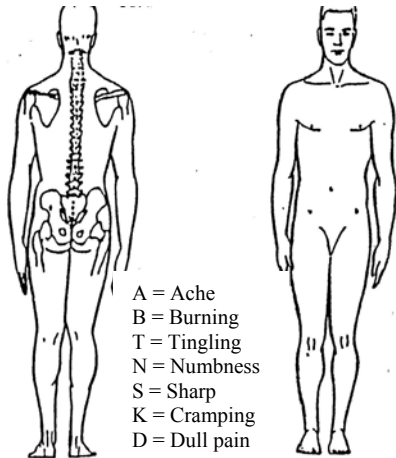
Please circle the motions that aggravate symptoms: bending, coughing, lifting, lying down, reaching, sitting, sneezing, standing, straining at stool, turning head, other: _____

Please circle the motions that relieve symptoms: bending, coughing, lifting, lying down, reaching, sitting, sneezing, standing, straining at stool, turning head, other: _____

Does your pain radiate? Yes No

-If yes, where does it radiate to? _____

**Please Circle the Areas of the Body
Where You Are Experiencing Pain**



Below, please circle the severity and intensity of your symptoms, at its worst:

Slight Mild Moderate Severe
1 2 3 4 5 6 7 8 9 10

On the scale below, please circle the percentage of time that you experience your main complaints:

Occasional Intermittent Frequent Constant
10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Review of Systems: If yes, please describe the condition on the line provided.

Recent weight loss or weight gain (how much): Yes No _____

Rashes, hives or lesions: Yes No _____

Hay fever, sinuses or nasal discharge: Yes No _____

Chest pain or palpitations: Yes No _____

Shortness of breath, wheezing or coughing: Yes No _____

Nausea, vomiting or diarrhea: Yes No _____

Frequency with urination or urgency to urinate: Yes No _____

Lymphadenopathy (swelling of lymph nodes): Yes No _____

Polyuria or polydipsia (excessive thirst or urination): Yes No _____

History of seizures or headaches (how often): Yes No _____

Social History (please circle):

Exercise Never Seldom Occasionally Regularly

Tobacco Usage None Light Moderate Heavy

Alcohol Usage None Light Moderate Heavy

Illegal Drug Usage None Light Moderate Heavy

RX Drug Usage None Light Moderate Heavy

FEMALES ONLY:

Are you pregnant? Yes No

Are you taking Birth Control? Yes No

This is to certify that to the best of my knowledge I am NOT pregnant and Dr. Joel D. Feeman and his associates have my permission to perform an x-ray evaluation if there is need. I have been advised that x-rays can be hazardous to an unborn child.

Signature _____ **Date** ____/____/____

Family Health History

The reason for this form is to assist the doctor by providing past health history information for their review.

Condition	Self	Father	Mother	Spouse	Brothers	Sisters	Children
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies							
Arthritis							
Asthma							
Back Trouble							
Cancer							
Constipation							
Diabetes							
Disc Problems							
Drug Addiction							
Ear Infections							
Emphysema							
Fibromyalgia							
Headaches							
Heart Trouble							
High Blood Pressure							
Hyperactivity/ ADHD							
Kidney Trouble							
Menstrual Cramps							
Migraine							
Neck Pain							
Nervousness							
Numbness							
Pinched Nerve							
Poor Circulation							
Scoliosis							
Shoulder/Arm/Hand							
Sinus Trouble							
Stomach Trouble							
Other: _____							