Application For Admission DRX
UNRUH CHIROPRACTIC AND WELLNESS CENTER

Today's Date _____

Name _____ Age _____

Address_____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

email_____ Birthday _____ Sex: ☐ M ☐ F

Social Security _____ Best place to reach you: ☐ Home ☐ Work ☐ Cell

May we leave a voice mail message for you? ☐ Yes ☐ No Occupation_____

Employer name _____ Length of Employ_____

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse's Name _____

Spouse's SS#_____ Names and Ages of Children_____

_____

IF THE PATIENT IS A MINOR, parents name _____

If your insurance doesn't cover your care are you willing to pay out of pocket?

☐ **Yes** ☐ **No**

How Did You First Hear About Unruh Chiropractic and Wellness Center?

_____

1. What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

   _____

2. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No
3. Is today's problem caused by ☐ Auto Accident ☐ Work Injury ☐ Other: _____
4. How do you think your problem began? _____
5. How long have you had this problem? _____
6. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

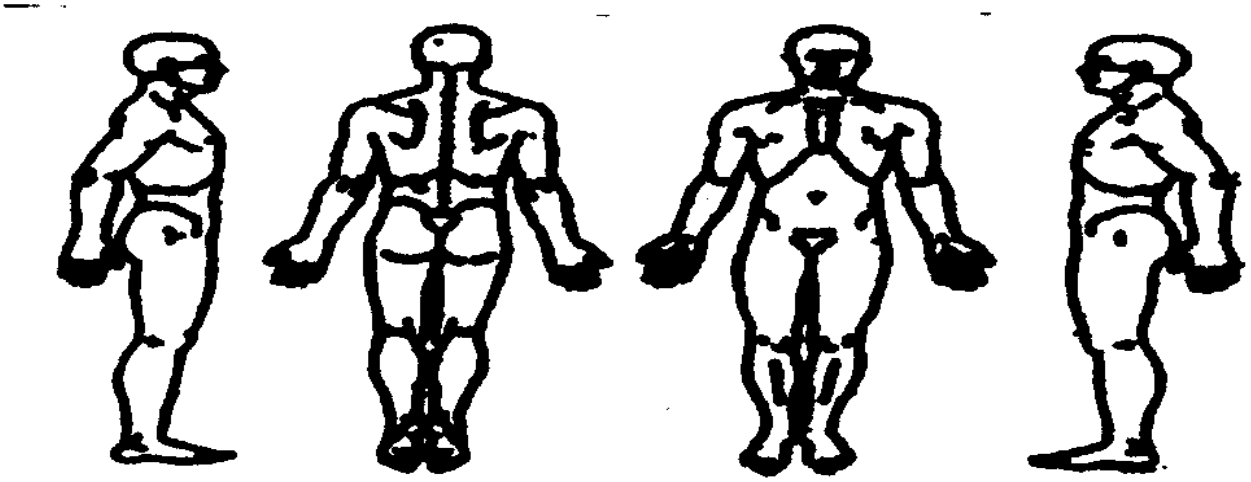
   _____

   _____

   _____

   _____

7. Indicate on the drawings below where you have pain/symptoms.



8. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (25-50% of the time)
- ☐ Intermittently (1-25% of the time)

9. How would you describe the type of pain?

- ☐ Sharp
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Stiff
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric-like with motion
- ☐ Other:_____

10. On a Scale of 0-10 (10 = unbearable, 0 No Pain or Discomfort) Please rate the following...

a. The HIGHEST your pain gets WITHOUT medication _____
b. The LOWEST your pain gets WITHOUT medication _____
c. The HIGHEST your pain gets WITH medication _____
d. The LOWEST your pain gets WITH medication _____

11. What aggravates your problem?

_____

_____

12. What concerns you the most about your problem; what does it prevent you from doing?

_____

_____

13. Is there anything you can do that makes it feel better?

_____

_____

14. When is it worse? ☐ In the morning ☐ As the day progresses on ☐ Night

15. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

16. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

17. Who else have you seen for your problem?

- ☐ Chiropractor
- ☐ ER physician
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ Physical Therapist
- ☐ Primary Care Physician
- ☐ Other:
- ☐ No one

18. What kinds of treatments have you received?

- ☐ Epidural: How Many _____ When (approx) _____
- ☐ Physical Therapy: How Long _____ When (approx) _____
- ☐ Medication: _____ When (approx) _____
- ☐ Surgery: Type_____ When (approx) _____
- ☐ Other_____

19. Did any of these treatments work? If so, which one(s)? For how long?

_____

_____

20. What are you hoping the Doctor tells you today?

_____

_____

21. Describe what you hope or think he might be able to do for you.

_____

_____

22. Describe what will be different in your life if you can get better.

_____

_____

23. **List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.**

a) _____
How Long Have You Had This? _____

b) _____
How Long Have You Had This? _____

c) _____
How Long Have You Had This? _____

d) _____
How Long Have You Had This? _____

24. What is your: Height:_____ Weight:_____ Age: _____

25. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

26. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

27. Indicate if you have any immediate family members with any of the following:

- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Lupus
- ☐ Heart Problems
- ☐ Cancer
- ☐ ALS

28. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Now" column:

Past	Now	Condition	Past	Now	Condition	Past	Now	Condition
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
☐	☐	Hip Pain	☐	☐	Loss of Bladder Control	☐	☐	Dermatitis, Eczema, Rash
☐	☐	Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Muscular Incoordination
☐	☐	Joint Pain/Stiffness	☐	☐	Ulcer	☐	☐	Visual Disturbances
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Abnormal Weight Gain / Loss
☐	☐	Rheumatoid Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	General Fatigue
☐	☐	Cancer	☐	☐	Asthma	For Women Only:		
☐	☐	Tumor	☐	☐	Chronic Sinusitis	☐	☐	Birth Control Pills
☐	☐	Other: _____				☐	☐	Hormonal Replacement
						☐	☐	Pregnancy

29. List all of the surgical procedures you have had: _____

_____

30. List all of the prescription medications you are currently taking: _____

_____

31. List all of the over-the-counter medications you are currently taking: _____

_____

32. What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

33. What activities do you do outside of work? _____

_____

34. Have you ever been hospitalized? ☐ Yes ☐ No If yes, why? _____

_____

35. Have you had significant past trauma? ☐ Yes ☐ No If yes, describe: _____

_____

36. Anything else pertinent to your visit today? _____

Terms of Acceptance & Privacy Policy

UNRUH CHIROPRACTIC AND WELLNESS CENTER

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine and extremities.

Health: a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

_____ Unruh Chiropractic & Wellness Center does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of the health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ I understand that I am responsible for all costs of incurred in course of my treatment, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ I understand and agree to allow Unruh Chiropractic & Wellness Center to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care and that all my medical records and personal contact information will be kept confidential.

I, _____ (print your name), have read and fully understand the above statements and all of the information I have provided is accurate to the best of my knowledge.

Signature: _____ Date: _____