



Application For Admission – DRX UNRUH CHIROPRACTIC AND WELLNESS CENTER

Congratulations! You have been fortunate enough to qualify for a **consultation** with the Doctor at no charge. However this does not mean that your case has been accepted. Your consultation today will determine if:

- A) You are a qualified candidate for this program and if
- B) Your condition is serious enough to warrant your case being accepted for treatment.

In the event you are qualified and your condition is serious enough to warrant being considered for treatment, if the Doctor is unavailable to treat you, your case will be referred to another clinic.

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

Employer _____

Occupation _____ Length of Employ _____

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

Spouse's SS# _____ Names and Ages of Children _____

I (signature) _____ consent to allow the Doctor to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for Chiropractic Care and also to determine if he is willing to accept my case. It is also my understanding that the consultation is free of charge and that all examinations fees will be communicated before examination is performed.

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?

How Serious Do You Think Your Problem Is? _____

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

Would You Consider This Problem:

- MINIMAL (Annoying but causing NO limitations)
- SLIGHT (Tolerable but causing a little limitation)
- MODERATE (Sometimes tolerable but definitely causing limitations)
- SEVERE (Causing Significant limitations)
- EXTREME (Causing near constant [>80% of the time] limitations)

1. 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?

2. What are you hoping happens today as a result of your consultation with the Doctor?

3. Since your condition became this severe what three things has it caused you to miss the most?

4. How long have you been like this?

5. How has your life changed since your condition became a problem?

6. What activities are you limited in?

7. 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 _____

8. When did you receive these treatments and for how long?

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

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

11. What activities/movements are guaranteed to make it worse?

12. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

13. Is it worse in the morning or is it worse as the day progresses?

14. If you cannot find a solution to this problem what do you think will happen to you?

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

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

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

18. When is the VERY FIRST time you recall having this problem?

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

1. _____
How Long Have You Had This? _____
2. _____
How Long Have You Had This? _____
3. _____
How Long Have You Had This? _____
4. _____
How Long Have You Had This? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem?

- Occasionally (25% of the time)
- Intermittently (50% of the time)
- Frequently (75% of the time)
- Constant (90-100% of the time)

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Family? Yes No

How Much Time and What Tasks Have Been Limited?

Have You Lost Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc...)

Yes No How Much Time and What Tasks Have Been Limited?

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?

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

The HIGHEST your pain gets WITHOUT medication _____

The LOWEST your pain gets WITHOUT medication _____

The HIGHEST your pain gets WITH medication _____

The LOWEST your pain gets WITH medication _____

List ANY surgeries that you have had and the corresponding dates:

**Have you had ANY of the following in the last 12 months or currently?
(Mark "C" for current, "X" for in last 12 months)**

GENERAL

<input type="checkbox"/>	Chills	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loss of Sleep	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Numbness to BOTH hands AND feet
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Loss of Weight		

CARDIOVASCULAR

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	Swollen Ankles
<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Slow Heartbeat	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Pain Over Heart	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	TIA	<input type="checkbox"/>	Bruise Easily
<input type="checkbox"/>	Previous Heart Problem (describe:)				

DISEASES/CONDITIONS

	Appendicitis		Depression		Low back Pain
	Anemia		Epilepsy		Mental Illness
	Arthritis		Eczema		Measles
	Alcoholism		Eating Disorder		Mumps
	Abdominal Surgery		Glaucoma		Pleurisy
	Bleeding Disorder		HIV +		Pneumonia
	Blood Clot(s)		Heart Disease		Polio
	Breathing Difficulty		Hernia		Prostate Problems
	Cancer		Headaches		Hyperthyroid
	Cholesterol High		Influenza		Hypothyroid
	Colon Problems		Kidney Disease		Rectal Surgery
	Diabetes		Liver Disease		

EARS/EYES/NOSE/THROAT

	Asthma		Difficulty Swallowing		Thyroid Problem
	Crossed Eyes		Deafness		Nose Bleeds
	Double Vision		Hearing Loss		Sinus Problems
	Blurred Vision		Ear Pain		Sore Throats

GASTRO-INTESTINAL

	Gas		Hemorrhoids		Poor Digestion
	Colon Trouble		Liver Trouble		Vomiting
	Constipation		Nausea		Vomiting Blood
	Diarrhea		Stomach Ache		Rectal Bleeding
	Gallbladder Trouble		Poor Appetite		Bloating

GENITO-URINARY

	Blood in Urine		Kidney Infection		Painful Urination
	Frequent Urination		Painful Urination		
	Inability to control urine		Prostate Trouble		

FOR MEN ONLY

	Lump in testicles		Penis discharge
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FOR WOMEN ONLY

	Menstrual Cramps		Irregular Cycle		Abnormal Pap Smear
	Excessive menstrual flow		Painful periods		
	Hot Flashes		Birth Control Pills		

MUSCLE/JOINT/BONE

	Backache		Painful Tailbone		Swollen Joints
	Foot Trouble		Stiff Neck		
	Pain Between Shoulders		Spinal Curvature		

NEUROLOGIC

	Seizures		Weakness		Loss of coordination
	Dizziness		Difficulty with speech		
	Hand Trembling		Loss of memory		

RESPIRATORY

	Chest Pain		Difficulty Breathing
	Chronic Cough		Coughing/Spitting Blood



Terms of Acceptance **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.

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.

We do 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, _____ (print your name), have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: _____ Date: _____