cornerstone
WELLNESS CENTER
your center for wellness

Patient Application for Treatment

Name_____ **How would you like to be addressed?**_____

Address_____**City**_____ **State**_____ **Zip** _____

Cell Phone_____**Email**_____

Date of Birth_____ **Age**_____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)* ❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____**Employer**_____ **Employer Phone** _____

Do you have insurance? ❑ Yes ❑ No **Insurance name:**_____

Primary insured? ❑ Yes ❑ No **If no, primary insured name and relationship to self:** _____

What is the best way to contact you? *(check one)* ❑ Email ❑ Cell Phone

Who can we thank for referring you? ❑ Patient Referral _____ ❑ Dr. Referral_____
❑ Law Firm _____ ❑Webpage ❑Google ❑Other_____

Emergency Contact:_____ **Phone #:**_____

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past.

****Please state (P) for Patient or (F) for family****

❑ Alcoholism **(P or F)**	❑ High Blood Pressure **(P or F)**	❑ Stroke **(P or F)**
❑ Anemia **(P or F)**	❑ Kidney Disease **(P or F)**	❑ Suicide Attempt **(P or F)**
❑ Asthma **(P or F)**	❑ Liver Disease **(P or F)**	❑ Thyroid Disease **(P or F)**
❑ Celiac disease **(P or F)**	❑ Hashimoto's disease **(P or F)**	❑ Trouble Sleeping **(P)**
❑ Cancer/Tumor **(P or F)**	❑ Hepatitis **(P or F)**	❑ Tuberculosis, TB **(P or F)**
❑ Crohn's disease **(P or F)**	❑ High Cholesterol **(P or F)**	❑ Ulcers **(P or F)**
❑ Diabetes **(P or F)**	❑ Lung Disease **(P or F)**	❑ Venereal Disease **(P or F)**
❑ Drug Abuse **(P or F)**	❑ Mental Illness **(P or F)**	❑ HIV or Other Immune Disease **(P or F)**
❑ Depression **(P or F)**	❑ Osteoarthritis **(P or F)**	❑ Fibromyalgia **(P or F)**
❑ Epilepsy/Seizures **(P or F)**	❑ Osteoporosis **(P or F)**	❑ Other _____ **(P or F)**
❑ Glaucoma **(P or F)**	❑ Phlebitis **(P or F)**	
❑ Heart Disease **(P or F)**	❑ Rheumatic Arthritis **(P or F)**	

PATIENT SIGNATURE: _____ DATE: _____ Dr. Initial _____

PATIENT NAME_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

Cigarettes a day:_____ **Packs a day:**_____ **Alcohol: Yes/No If yes, drinks per week:** _____

Exercise frequency _____ **Recreational drug use? Yes / No**

Current medications, including dosage if known: **If there are no current medications, check here: ❑**

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

Have you ever had allergy testing done? ❑ Yes ❑ No **If yes, when?**_____

List any known allergies you have had to any medications, foods or environment:

If no allergies are known, check here: ❑

1) _____ **3)** _____

2) _____ **4)** _____

5) _____ **6)** _____

Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ❑ Yes ❑ No

If yes, describe:_____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

Primary Care Physician _____**Address**_____ **Phone**_____

When was your last Physical examination? _____

When did you last have blood work? ❑ Within a Year ❑ Over a Year ❑ Not Sure

Have ever been referred to a specialist? ❑ Yes ❑ No If yes, describe;_____

Have you ever had chiropractic care? ❑ Yes ❑ No

If Yes, how long has it been since you've seen a chiropractor? _____

Has any of your family received chiropractic care? ❑ Yes ❑ No

Please list any and all surgeries you have had and an approximate date of procedure: _____

_____

_____

_____

_____

_____

PATIENT SIGNATURE: _____ DATE: _____ Dr. Initial _____

PATIENT NAME: _____

1. Chief Complaint : _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

2. Chief Complaint : _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

3. Chief Complaint : _____
Circle the current pain level of your complaint:
1 2 3 4 5 6 7 8 9 10
Mild Severe

When did it start? _____ Gradual / Sudden
Circle the percentage of day you experience the complaint:
10 20 30 40 50 60 70 80 90 100
How would you rate the pain at its worst? (1 – 10) _____

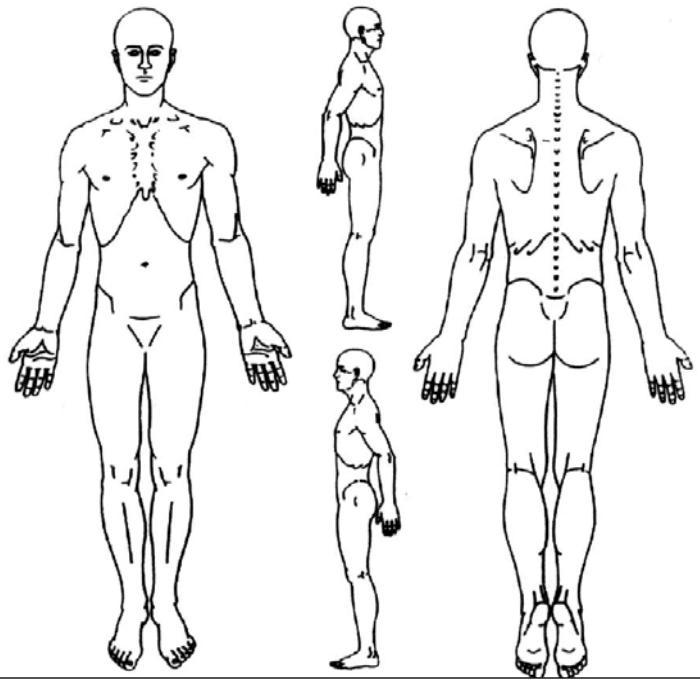
What job activities are you unable to do? _____

When do you feel it most? □ AM □ PM When present, how long does the complaint last? _____Mins _____Hrs

What makes it feel better? _____ What makes it feel worse? _____

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

A: Ache
B: Burning
C: Cramping
D: Dull Pain
F: Stiffness
N: Numbness
R: Throbbing
S: Soreness
T: Tingling
X: Sharp Pain
SP: Shooting Pain
RP: Radiating Pain



Do you currently have pain and/or difficultly performing any of the following activities? (Circle Y or N)

Walking	Y	N
Computer work	Y	N
Standing	Y	N
Running	Y	N
Sleeping	Y	N
Driving	Y	N
Personal Grooming	Y	N
Sitting	Y	N
Kneeling	Y	N
Exercising	Y	N
Bending	Y	N
Lifting Objects	Y	N
Lifting Children	Y	N
Housework	Y	N

1. Have you ever had tests for your present condition? □ MRI □ Xray □ CT □ Other _____
2. Do you have a pacemaker? □ Yes □ No Do you have any artificial joints or metal in other regions?_____
3. Have you ever lost work due to your condition(s)? □ Yes □ No If Yes, dates? _____
4. Are you pregnant? □ Yes □ No Number of pregnancies? _____ Number of miscarriages? _____
5. What was the first day of your last menstrual cycle? _____

If you have not been in the office in over 30 days a re-examination may be necessary and an additional charge may occur.

In the event we can help, please indicate to us what your level of commitment would be to correcting your problem(s)?

Low Medium High
0 1 2 3 4 5 6 7 8 9 10

What is YOUR goal for treatment? _____

By signing below, I acknowledge that the above information is true and accurate to the best of my knowledge:

Patient Name (please print): _____

Patient Signature: _____ Date: _____ Dr. Initials _____

STAFF USE ONLY **Height:** _____inch **Weight:** _____ pounds **BP**_____ /_____ P _____