

APPLICATION FOR TREATMENT

| |
|---|
| Date _____ |
| Name _____ Age _____ Birthdate _____ |
| Address _____ City _____ State _____ ZIP _____ |
| Home Phone _____ Phone at Work _____ Cell Phone _____ |
| E-Mail Address _____ |
| Whom should we thank for the Referral? _____ |
| Circle if you are: Married Single Widowed Divorced Separated |
| Employer _____ Occupation _____ |
| ● Please describe the main reason(s) for which you came to this office. _____ |
| ● On a scale from 0-10, with 10 being unbearable pain, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 |
| ● When and how did symptoms first occur? _____ |
| _____ |
| ● List any other doctors seen for these problems _____ |
| _____ |
| ● List diagnosis(es) and type of treatment(s) _____ |
| _____ |
| ● Does this interfere with your normal living and work? Yes No If yes, In what way? _____ |
| _____ |
| ● Have you lost any days of work? Yes No Dates _____ |
| _____ |
| ● Have you had similar symptoms or injuries before? Yes No If yes, explain _____ |
| _____ |
| ● List the names of any relatives that have or have had a similar problem _____ |
| _____ |
| ● Who is responsible for your bill (please circle)? Self Spouse Employer Insurance Other _____ |

PAST HISTORY

| |
|--|
| ● Has a physician treated you for any health condition in the last year? Yes No If yes, explain: _____ |
| _____ |
| ● Have you or any relative received Chiropractic treatment previously? Yes No If yes, explain: _____ |
| _____ |
| ● List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) _____ |
| _____ |
| ● List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) _____ |
| _____ |

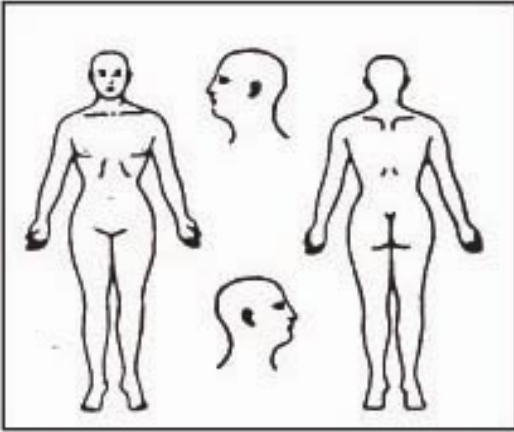
FAMILY CONTACTS

| | |
|-------------------------------|------------------------|
| Name of wife or husband _____ | Ages of children _____ |
| Spouse's Employer _____ | Business Phone _____ |
| Your Nearest Relative _____ | |
| Relative's Address _____ | Phone Number _____ |

PLEASE TURN OVER

CURRENT CONDITION

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down)

1. _____
2. _____
3. _____
4. _____

CONSENT TO RECEIVE TREATMENT

FEEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient _____ Social Security Number _____

Date _____

INSURANCE INFO

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Schuster Chiropractic for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signature _____ Date _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients. (PLEASE CIRCLE)

1. Do you or your spouse work for a company that provides you with health insurance? **Yes** **No**
2. Are you entitled to Medicare because of End Stage Renal Disease? **Yes** **No**
3. Is this illness or injury the result of an accident or other injury? **Yes** **No**
4. Is this illness or injury the result of an accident or illness that occurred at work? **Yes** **No**
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? **Yes** **No**
6. Are you entitled to any benefits under the Federal Black Lung Program? **Yes** **No**
7. Do you have a Medicare Medigap Policy? **Yes** **No**
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from) **Yes** **No**

Signature _____ Date _____

PATIENT HEALTH QUESTIONNAIRE

Name _____ Date _____

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

| Past | Present | Condition | Past | Present | Condition |
|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain Loss | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia | <input type="checkbox"/> | <input type="checkbox"/> | Muscular In-coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Ankle or Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Lower Leg or Knee |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm or Elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Leg or Hip |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast Soreness Lumps | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Explain _____ | <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation/irregular bowel habits | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke (Date) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Swelling, Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash | <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, Explain _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain (R_____ L_____) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches, frequency? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack (date) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/Indigestion | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Menstrual Flow | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Colon | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain (TMJ Pain) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders (by condition) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gallbladder problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite | | | |

Have You or Your Family Had:

| Yes | No | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Back Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |

Do you have a permanent disability rating? Yes__ No__
 Location _____
 Date rating received ? Rating Percentage _____

Height _____ Feet _____ Inches Weight _____ Pounds

Please check any of the following that apply to you

| Past | Present | | Past | Present | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy, # births _____ | <input type="checkbox"/> | <input type="checkbox"/> | Tobacco ___ packs/day |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth control pills, Type _____ | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol __ drinks/day/week/month |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication (list if not listed elsewhere) | <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| | | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Coffee/Tea/Caffeinated Soft drinks |
| | | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ cups/cans per day |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospitalizations/Surgical Procedures (List if not described elsewhere) _____ | | | |

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this Doctor immediately whenever I have changes in my health condition

Signature

Date