15215 S 48th St. Bldg 5, Ste. 156
Phoenix, AZ 85044
P. (480) 704-8818 F. (480) 704-8819

back in line spine & wellness

Patient Application for Treatment

Name____ **Nickname**_____________________________________

Date of Birth____________________ **Age**_______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Height:** _____ft______in **Weight:** ____________pounds

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

Occupation__________________________**Employer**___________________________

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

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

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

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest ***Very Interested***

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

1) ____ **5)** ____

2) ____ **6)** ____

3) ____ **7)** ____

4) ____ **8)** ____

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

If no allergies are known, check here: ❑

1) ____ **3)** ____

2) ____ **4)** ____

Have you had food allergy testing done before? ❑ Yes ❑ No

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

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

If yes to Diabetes, what was your last hemoglobin A1c? _____________________ ❑ Not Sure

When was your last Physical examination? _________________________________

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

Surgeries: ____

PATIENT SIGNATURE: _____________________________________ DATE: ______________ Dr. Initial ________

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PATIENT NAME: ___________________________

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

****Please circle (P) for Personal or (F) for Family****

- ❑ Alcoholism **(P or F)**
- ❑ Anemia **(P or F)**
- ❑ Asthma **(P or F)**
- ❑ Cancer/Tumor **(P or F)**
- ❑ Diabetes **(P or F)**
- ❑ Drug Abuse **(P or F)**
- ❑ Depression **(P or F)**
- ❑ Epilepsy/Seizures **(P or F)**
- ❑ Rheumatic Arthritis **(P or F)**
- ❑ High Blood Pressure **(P or F)**
- ❑ Kidney Disease **(P or F)**
- ❑ Liver Disease **(P or F)**
- ❑ Hepatitis **(P or F)**
- ❑ Lung Disease **(P or F)**
- ❑ Mental Illness **(P or F)**
- ❑ Osteoarthritis **(P or F)**
- ❑ Osteoporosis **(P or F)**
- ❑ Stroke **(P or F)**
- ❑ Suicide Attempt **(P or F)**
- ❑ Thyroid Disease **(P or F)**
- ❑ High Cholesterol **(P or F)**
- ❑ Ulcers **(P or F)**
- ❑ Heart Disease **(P or F)**
- ❑ HIV or Other Immune Disease **(P or F)**
- ❑ Glaucoma **(P or F)**
- ❑ Other **(P or F)**

Please check any conditions that you have now or have had in the past

GENERAL
- ❑ Weight Loss
- ❑ Fatigue
- ❑ Fever

EYES
- ❑ Glasses/Contacts
- ❑ Eye Pain
- ❑ Double Vision
- ❑ Cataracts

EAR, NOSE, THROAT
- ❑ Difficulty Hearing
- ❑ Ringing in Ears
- ❑ Vertigo/Dizziness
- ❑ Sinus Trouble
- ❑ Nasal Stiffness
- ❑ Frequent Sore Throat

CARDIOVASCULAR
- ❑ Heart Murmur
- ❑ Chest Pains
- ❑ Palpitations
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Difficulty Lying Flat
- ❑ Swelling Ankles

ENDOCRINE
- ❑ Loss of Hair
- ❑ Heat/Cold Intolerance

RESPIRATORY
- ❑ Coughing
- ❑ Coughing Blood
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Heartburn/Reflux
- ❑ Nausea/Vomiting
- ❑ Constipation
- ❑ Change in BMs
- ❑ Diarrhea
- ❑ Jaundice
- ❑ Abdominal Pain
- ❑ Black/Bloody BM

GENITOURINARY
- ❑ Painful Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Erectile Dysfunction
- ❑ Abnormal Discharge
- ❑ Bladder Leakage

ALLERGIES
- ❑ Hives/Eczema
- ❑ Hay fever

PYSCHIATRIC
- ❑ Anxiety/Depression
- ❑ Mood Swings

HEMATOLOGY
- ❑ Easy Bruising
- ❑ Bleeding Gums
- ❑ Enlarged Glands

MUSCULOSKELETAL
- ❑ Joint Pain/Swelling
- ❑ Stiffness
- ❑ Numbness in toes/fingers
- ❑ Weakness in hands, feet, arm or legs
- ❑ Muscle Pain
- ❑ Loss of muscle Strength
- ❑ Back Pain

SKIN
- ❑ Rash/Sores
- ❑ Hives
- ❑ Lesions

NEUROLOGICAL
- ❑ Headaches
- ❑ Tremors
- ❑ Memory Loss

FEMALES ONLY

Date of Last Mammogram _____
Normal
Abnormal
Date of Last Pap ______
Normal
Abnormal
Date of Last Period _____
Are you pregnant? Y / N

When was the last time you were involved in an accident of any kind, please describe?___________________________

____

Briefly list your main health problems and reason for visit today: ___________________________

____

PATIENT SIGNATURE: ______________________ DATE: ______________Dr. Initial ________

RV 7/15

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PATIENT NAME: ___________________________

1. **Chief Complaint** : ________________________ When did it start? ________________ Gradual / Sudden

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

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** : ________________________ When did it start? ________________ Gradual / Sudden

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

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** : ________________________ When did it start? ________________ Gradual / Sudden

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

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? ____

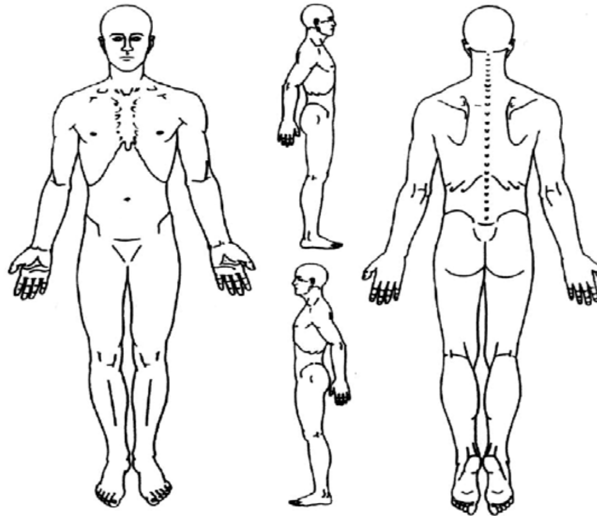
What time of day is your pain at it's worst? AM PM **How long does your pain last**? _________Mins _________Hrs

What makes your pain better? ____

What makes your pain worse? ____

Using the letters below, please show where you are experiencing all 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
SM: Spasm



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

Activity		
Walking	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 2b. If yes, what medications are you currently taking? ________________
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? __________

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 _______