



**Alex Zylstra DC**  
7517 Custer Rd. W.  
Lakewood, WA 98499  
(253) 473-7777

## CONFIDENTIAL PATIENT APPLICATION

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex M F Marital Status S M W D

How many children? \_\_\_\_\_ Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Name of Spouse (or responsible party, if minor) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Referred by:** \_\_\_\_\_

Do you have medical insurance? Y N *If yes, please give us your card so that we can make a copy of it.*

## ACCIDENTS/FALLS/OTHER INJURIES

Auto Accidents Y or N How recent \_\_\_\_\_ Treatment Y or N

Past Work Injuries Y or N How recent \_\_\_\_\_ Treatment Y or N

Other Injuries Y or N How recent \_\_\_\_\_ Treatment Y or N

Have you received chiropractic care before? Y or N

If yes, with Dr. \_\_\_\_\_ Where \_\_\_\_\_ Last Visit \_\_\_\_\_

Did you have good results? Y or N

# PRESENT COMPLAINTS

Please explain the symptoms you have by **circling** or **writing** in the space provided. If you are unsure, please leave it blank.

## HEADACHES

How long have you been having headaches? \_\_\_\_\_

How often do you have headaches? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** \_\_\_\_\_

Which side do you normally get your headaches? **Right/Left/Both Sides** \_\_\_\_\_

Where are your headaches? **Back of the head /Side of the head/Temples/Top of the head/In the Eyes/In the sinuses** \_\_\_\_\_

Can you describe the headache? **Sore/Achy/Dull/Throbbing /Sharp/Stabbing/Migraine Pressure** \_\_\_\_\_

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your headache better or go away? \_\_\_\_\_

Does anything make your headache worse? \_\_\_\_\_

Do you get dizziness with your headaches? **Yes/No** \_\_\_\_\_

Do you get ringing in the ears with your headaches? **Yes/No** \_\_\_\_\_

Do you get blurry vision with your headaches? **Yes/No** \_\_\_\_\_

Do you get sinus problems or seasonal allergies? **Yes/No** \_\_\_\_\_

Do you have any of the following jaw problems? **Pain/Clicking/Popping/Clenched teeth/Grinding teeth**

## NECK

How long have you been having neck symptoms? \_\_\_\_\_

How often do you have neck symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** \_\_\_\_\_

Which side do you normally get your neck symptoms on? **Right/Left/Both Sides**

Can you describe your neck symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or Stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your neck symptoms better or go away? \_\_\_\_\_

Does anything make your neck symptoms worse? \_\_\_\_\_

Do you get any pain, numbness, tingling or weakness into the arms or hands? **Yes/No** Please Describe.

## MIDDLE BACK

(From the base of the neck to the bottom of the ribs)

How long have you been having middle back symptoms? \_\_\_\_\_

How often do you have middle back symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** \_\_\_\_\_

Which side do you normally get your middle back symptoms on? **Right/Left/Both Sides**

Can you describe your middle back symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your middle back symptoms better or go away? \_\_\_\_\_

Does anything make your middle back symptoms worse? \_\_\_\_\_

Do you ever have pain when taking a full breath in or out? **Yes/No** \_\_\_\_\_

## LOWBACK AND HIPS

How long have you been having low back or hip symptoms? \_\_\_\_\_

How often do you have low back or hip symptoms? **Constant/Daily/5-6 times a week/3-4 times a week/1-2 times a week/1 time every 2 weeks/1 time a month** \_\_\_\_\_

Which side do you normally get your low back or hip symptoms on? **Right/Left/Both Sides**

Can you describe your low back or hip symptoms? **Sore/Achy/Dull/Throbbing/Sharp/Stabbing/Stiff/Burning/Shooting**

**On a scale of 0-10, zero being no pain at all and ten being the worst imaginable pain,**

How would you rate your pain or stiffness? **0 1 2 3 4 5 6 7 8 9 10**

Do you do anything to make your low back or hip symptoms better or go away? \_\_\_\_\_

Does anything make your low back or hip symptoms worse? \_\_\_\_\_

Do you get pain, numbness, tingling or weakness into your legs or feet? **Yes/No** \_\_\_\_\_

## OTHER

**If you have any other conditions or problems that you are concerned about, please describe below.**

---

---

---

---

# Quality of Life Questionnaire

*Please rate your ability to perform the following activities*

## Work Activity Performance

- |                        |                               |                                  |                                  |                                 |
|------------------------|-------------------------------|----------------------------------|----------------------------------|---------------------------------|
| Squatting              | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Bending                | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Sitting                | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Standing               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Grasping               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Working Above Shoulder | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Lifting                | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Hand/Wrist Motion      | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Foot/Ankle Motion      | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| _____                  | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |

## Daily Activity Performance

- |                       |                               |                                  |                                  |                                 |
|-----------------------|-------------------------------|----------------------------------|----------------------------------|---------------------------------|
| Washing/Bathing       | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Dressing              | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Sweeping/Vacuuming    | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Dishes                | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Laundry               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Yard Work             | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Sexual Activity       | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Lifting               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Climbing Steps        | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Walking               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Sleeping              | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Driving               | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Concentrating/Reading | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| _____                 | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |

## Recreational Performance

- |                 |                               |                                  |                                  |                                 |
|-----------------|-------------------------------|----------------------------------|----------------------------------|---------------------------------|
| Running/Jogging | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Lifting Weights | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Yoga            | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| Other Exercises | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |
| _____           | <input type="checkbox"/> Able | <input type="checkbox"/> Limited | <input type="checkbox"/> Painful | <input type="checkbox"/> Unable |

**MEDICATIONS:** What medications are you currently taking, and for what conditions?

---



---



---



---

**SURGERIES:** Please list any surgeries you have undergone, and/or any surgeries you plan to have.

---



---



---



---



- **Open adjusting rooms:** We keep an open environment in the office to create a sense of warmth, family, healing and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member will speak with you about your condition or other matters in the closed private exam room.
- **To Family and Close Friends Involved in Your Care:** Our office has an open, family-centered approach to wellness and we believe it is in all our patient's best interests to have the support and cooperation of their families. Therefore, our office requires that the spouse or significant other be present when the doctor goes over the patient's report and recommendations for treatment and wellness. *If you object to the presence of your spouse or significant other at your report, please let us know immediately and we can refer you to another chiropractor.*

In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

- **Requesting Restrictions:** You have the right to request a restriction in how we use or disclose your PHI. However, we are not required to agree to your request. For instance, if you request that your spouse or significant other not be present when the doctor presents your report to you, we will not agree to such request.

**I hereby state that the information on all pages of this form is true and correct. I have been informed and understand that in the practice of chiropractic there are some extremely rare risks to treatment including, but not limited to, muscle strains, joint sprains and disc injuries. I do not expect the doctor to be able to anticipate and explain all risks and complications. I authorize Millennium Chiropractic to examine, x-ray, and utilize any means necessary to diagnose my condition in accordance with the state statutes, for the care and management of my condition. I am giving my consent to Millennium Chiropractic to cover the entire course of treatment for my present and any future conditions for which I seek treatment.**

**I clearly understand and agree that all services rendered to me are charged directly to me and/or my insurance carrier and that I am personally responsible for payment. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless specific arrangements are approved in writing by the doctor.**

**Patient/Spouse/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_**