PARK CITIES
FUNCTIONAL WELLNESS
SMU ATHLETIC DEPARTMENT DOCTOR

3408 Milton Ave
Dallas, TX 75205
214-739-2225
parkcitieschirosport@gmail.com

Date: _____ / _____ / 20____

INITIAL APPLICATION FOR CARE

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ /_____ /_____ Sex: ☐Male ☐Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Phone#: _____ Social Security#: _____

Will you be using insurance? ☐Yes ☐No Ins. Co. Name: _____ Policy Number: _____

Group Number: _____ Ins. Co. Phone Number on Card: _____

Is today's visit the result of an accident? ☐Yes ☐No **If yes,** please provide claim number: _____

Emergency Contact Name/ Number: _____ /_____ Relationship: _____

Primary Care Physician: _____ Doctor's Phone: _____

How did you hear about our office? _____

HEALTH CONCERNS

Primary Concern: _____ Secondary Concern: _____

_____ _____

_____ _____

On a scale of **0** to **10** with **ZERO** being none at all and **TEN** being the worst possible, please rate your above concerns by ***checking the box:***

Primary concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
Second concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

When did the problem(s) begin? _____/_____/_____

How did it happen? _____

When is the problem at its worst? ☐AM ☐PM ☐mid-day ☐ late night

How long does it last? ☐Constant ☐Off and on during the day

What does it feel like? _____

ON THE DIAGRAM please mark your symptoms using the following letters:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness
S = Sharp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms worse? _____

Any other facts about this current issue that you feel the doctor should know about?

_____

_____

PREVIOUS HISTORY

Have you experienced these same issues in the past? ☐Yes ☐No **If yes,** how long have you been dealing with them?_____

Have you tried other treatments in the past? ☐ Yes ☐ No **If yes,** please list all previous doctors you have seen: _____

As well as any and all products, procedures, medications, or supplements you have tried prior to now for this condition: _____

What were the results of your prior treatments? _____

QUALITY OF LIFE QUESTIONNAIRE

How has your health condition(s) affected your job? Your finances? Your relationships? Your family? Your hobbies or other activities? Please give examples:

What has that ended up costing you? (Time, Money, Freedom, Sleep, Promotions, Happiness, etc.) Please give examples:

What are you most concerned about regarding your condition?

Where do you see yourself in the next 1-3 years if this problem is not taken care of? Please be specific:

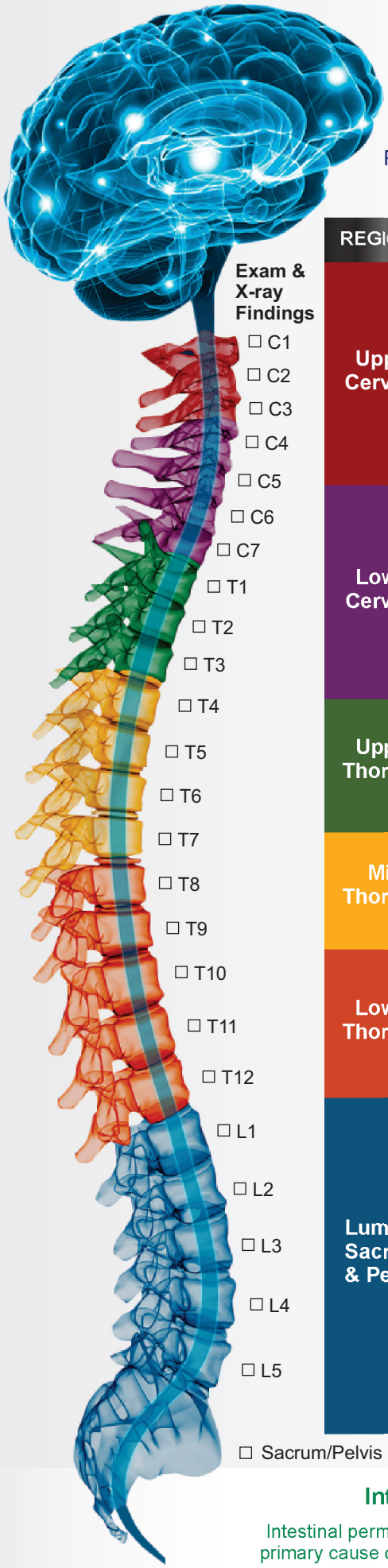
What would instantly be different or better about your life if we could take this problem away immediately?

What do you desire most to get from working with us?

Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please answer the following symptom checklist as thoroughly as possible by marking if you have **ever had** or **currently have** any of the following.



Exam & X-ray Findings

- ☐ C1
- ☐ C2
- ☐ C3
- ☐ C4
- ☐ C5
- ☐ C6
- ☐ C7
- ☐ T1
- ☐ T2
- ☐ T3
- ☐ T4
- ☐ T5
- ☐ T6
- ☐ T7
- ☐ T8
- ☐ T9
- ☐ T10
- ☐ T11
- ☐ T12
- ☐ L1
- ☐ L2
- ☐ L3
- ☐ L4
- ☐ L5
- ☐ Sacrum/Pelvis

REGIONS	FUNCTIONS	SYMPTOMS	
		☐ PAST ☐ PRESENT	☐ PAST ☐ PRESENT
Upper Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues
Lower Cervical	• Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands ☐☐ Poor Circulation/cold Hands	☐☐ TMJ / Jaw Pain ☐☐ Neck and shoulder pain ☐☐ Nausea/vomiting ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function • Upper Back Pain	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma ☐☐ Mid Back Pain	☐☐ Bronchitis & Pneumonia ☐☐ Heart Conditions ☐☐ Irregular Heart Beat ☐☐ Low Blood Pressure
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Fatigue ☐☐ Chronic Pain ☐☐ Inflammation	☐☐ Psoriasis and Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating ☐☐ Chronic Stress
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Mucus or Blood in Stool ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility / Impotency ☐☐ Hemorrhoids ☐☐ Hip/ Knee Pain	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Pain, Numbness, and Tingling in Legs and Feet ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Food Sensitivities

Intestinal Permeability/Leaky Gut Index Score_____

Intestinal permeability (aka leaky gut) is seldom tested for in general medical practice, but it is the primary cause of many chronic health issues we face today. All green shaded items throughout this form are used in the calculation of this score.

ACTIVITIES OF DAILY LIVING LIMITATIONS

Please identify how your current condition is affecting your ability to carry out activities of your daily life:

ACTIVITY	EFFECT			
Carry/Lift Groceries	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Pet Care	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Tend to Children	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Shaving	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Washing/ Bathing	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Sleeping	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Sitting	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Standing	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Yard Work	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Walking	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Driving	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Washing Dishes	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Taking out Garbage	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Doing Laundry	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Other_____	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Other_____	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform
Other_____	☐ No Effect	☐ **Slightly** Limited	☐ **Very** Limited	☐ Unable to Perform

Comments on any of the above tasks: _____

_____

SOCIAL HISTORY

Exercise frequency *Type?* _____

☐ Daily ☐ 3-4xs/wk ☐ 1-2xs/wk ☐ Rarely ☐ Never

Caffeine Usage _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Alcohol Usage _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Tobacco Usage *Type and amount?* _____

☐ Daily ☐ Occasional ☐ Former ☐ Never

Recreational Drug Usage _____

☐ Daily ☐ Occasional ☐ Former ☐ Never

NSAID Usage (Tylenol, Aspirin, Ibuprofen, etc.) _____

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Antibiotic Usage _____

☐ twice or more per year ☐ 1x/year ☐ 1-2 times ever ☐ Never

Comments: _____

_____

PREVIOUS MEDICAL HISTORY

Please mark if you have **EVER HAD** any of the following conditions. Use the comments section to provide details:

Illnesses and Injuries

☐ Cancer	☐ Arthritis/Joint Pain	☐ Aneurysm
☐ Tumors	☐ Osteoporosis	☐ CVA/TIA (stroke)
☐ Seizures	☐ Broken bones	☐ Heart Attack
☐ Diabetes	☐ Dislocations	☐ Blood Clots
☐ Autoimmunity	☐ Car Accident	☐ Heart Disease
☐ Fibromyalgia	☐ Concussions	☐ Other_____

Hospitalizations and Surgeries

Procedure	Date Performed
☐ Orthopedic	____/____/_____
☐ Spinal	____/____/_____
☐ Cancer	____/____/_____
☐ Other_____	____/____/_____
☐ Other_____	____/____/_____

Comments: _____

_____

_____

FAMILY HISTORY

Has anyone in your immediate family (Parents, Grandparents, Siblings, or Children) suffered from any of the following?

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Aneurysm ☐ Cancer ☐ Diabetes ☐ Other

☐ Unknown or Unremarkable (No history of disease or illness)

If yes, please explain: _____

_____

_____

CURRENT MEDICATIONS/SUPPLEMENTS

Please list all medications, drugs, and supplements you currently take, the dosage, and the reason you take them:

☐ Separate List Attached

Medication/Product	Dosage	Reason You Take Them	Date Started

ALLERGIES

Do you have any allergies to medications, supplements, foods, or other? ☐ **No known allergies** ☐ **Yes**

If Yes, please provide details on what the allergy is to, symptoms you experienced, what you currently do for treatment, and if it is well controlled or not. _____

_____

_____

I have answered the above questions on this form to the best of my ability, and certify them to be true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to P.C. Functional Wellness for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability, and that I will remain financially responsible to P.C. Functional Wellness for any and all services I receive at this office.

Patient or Authorized Person's Signature

_____/_____/_____
Date Completed

Doctor's Signature

_____/_____/_____
Date Completed

SUBMIT