NOVA IH 2675 N. Ankeny Blvd., STE 113, Ankeny, IA 50023

Application for Treatment (Please Print Clearly)

Name:		Social Security#:		Date:
Date of Birth:	Age:	Sex: M F	Marital Status M S D W	# of children:
Address:				
City:	State:	Zip:	E-mail:	
Home Phone #:		Cell #:		
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone ☐ Email				
Spouse's Name:		Spouse's DOB (Insurance Purposes)		
Occupation (Current or Previous)				Retired: Y N
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N
In Case of Emergency Contact Name:		Phone Number:		

TELL US ABOUT YOUR PAST HEALTH:

Y	N	← Lower Back Pain	Y	N	← Diabetes (A1C = _____)	Y	N	← High Cholesterol
Y	N	← Leg or Foot Pain/Numbness	Y	N	← Hand Problems	Y	N	← Shingles
Y	N	← Prior Spinal Surgeries	Y	N	← Neuropathy	Y	N	← Knee Surgery
Y	N	← Spinal Fractures	Y	N	← Heart Attack	Y	N	← Kidney issues or Dialysis
Y	N	← Spinal Stenosis	Y	N	← Heart Problems	Y	N	← Gout
Y	N	← Spinal Arthritis	Y	N	← High / Low Blood Pressure	Y	N	← Hip Surgery
Y	N	← Sciatica	Y	N	← Vascular Leg Problems	Y	N	← Leg Fractures
Y	N	← Neck Pain	Y	N	← Vascular Surgery	Y	N	← Joint Replacement
Y	N	← Herniated Disc	Y	N	← Stroke	Y	N	← Foot Surgery
Y	N	←Have you fallen in the last year	R	L	←Dominant Hand	Y	N	←Do you have difficulty hearing
Y	N	←Other Surgeries/ Health issues						
Please List:								

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST WEEK:

Y	N	← Recent Fever, Chills or Night Sweats	Y	N	← Chest Pain, Palpitations, or Irregular Beat
Y	N	← Frequent Headaches, Dizziness	Y	N	← Pacemaker/Defibrillator Placed (Ever)
Y	N	← Blurred or Double Vision, Eye Surgery	Y	N	← GI Issues, Constipation, or Diarrhea
Y	N	← Hearing Difficulties or Ear Pain	Y	N	← Nausea or Vomiting
Y	N	← Nasal Congestion or Sore Throat	Y	N	← Difficulty Urinating, Frequent or Painful
Y	N	← Dental Carries or Infection	Y	N	← Joint or Muscle Pain, Swelling
Y	N	← Pain or Decreased Movement, Neck Injuries	Y	N	← Memory Loss or Confusion, Forgetfulness
Y	N	← Congestion, Wheezing, Shortness of Breath	Y	N	← Balance Problems or Loss of Coordination
Y	N	←Skin Lesions, Wounds, Sores, Slow Healing	Y	N	←Depression or Anxiety
Y	N	←Known Hormone or Thyroid Problems			

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU ARE CURRENTLY TAKING, OR ATTACH LIST:

PLEASE LIST ANY ALLERGIES:

SOCIAL HISTORY:

Substance Usage					
Alcohol □ NO	□ YES →	□ Rarely	□ Occasionally _____ per/week	□ Heavy _____ per/day	□ Recovering Alcoholic
Recreational Drugs □ NO	□ YES →	Type Used:		How Often:	
Tobacco □ NO	□ YES →	□ Cigarette Packs/day -	□ Dip	□ Chew	□ Previously, and quit- _____ years ago

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:	
NAME OF YOUR PRIMARY CARE PHYSICIAN:	
MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT?: □ YES □ NO	
PLEASE LIST BELOW ANY **SURGERIES** YOU'VE HAD?	
DO YOU EXERCISE REGULARLY? □ NO □ YES →	How Many Minutes/Day_____ How Many Days/Week_____
ARE YOUR SYMPTOMS **WORSE AT**? ☐ Morning ☐ Afternoon ☐ Night ☐ Constant	

WHAT KIND OF PROBLEM(S)/ ISSUE(S) BRING YOU HERE:
HOW AND WHEN DID IT START?
DID YOU HAVE SURGERY? ☐ YES ☐ NO PROCEDURE:_____ DATE OF SURGERY?_____
WHAT TEST HAVE YOU HAD? ☐ X-RAY ☐ MRI ☐ CT SCAN ☐ EMG ☐ BONE SCAN ☐ OTHER_____
WHAT TREATMENTS HAVEN YOU HAD? ☐ PHSCIAL THERAPY ☐ MASSAGE ☐ CHIROPRACTIC ☐ OTHER _____
WHAT MAKES IT BETTER:
WHAT MAKES IT WORSE:

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Grinding	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Tightness	Swelling	Tiredness	Cramping
	Vertigo	Imbalance	Motion Intolerance	Ear pressure/pain		Light Headedness	

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)						
WORK	**SLEEP**	**DAILY ROUTINE**	**CHORES**	**WALKING**	**STANDING**	**BALANCE**

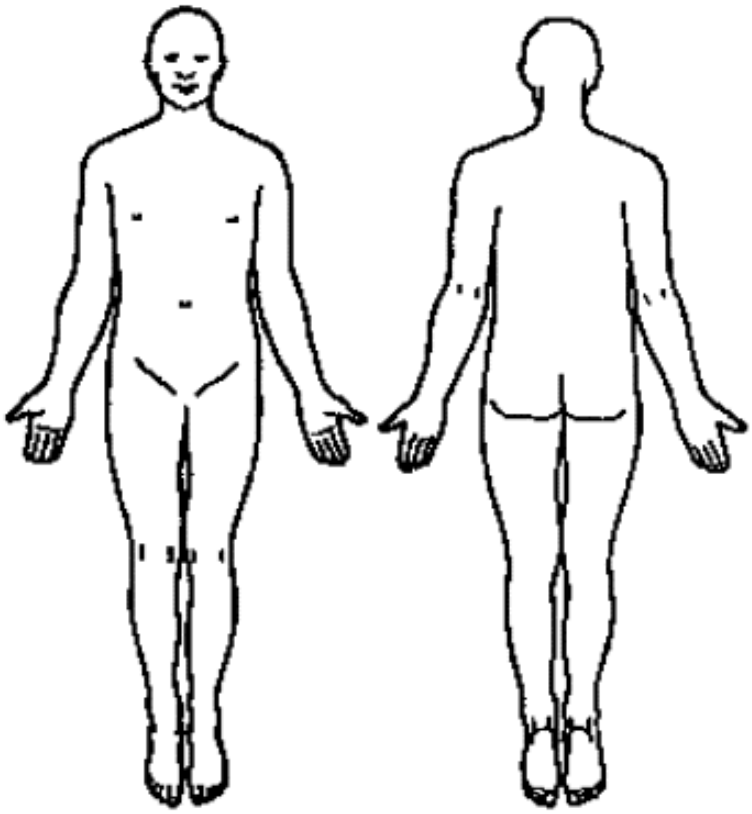
How would you describe your average pain over the past week?

No pain **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?

No pain **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:



Which of the following is **true** for your condition: (check one of the following)		
____ It's getting better on it's own	____ It's staying the same	____ It's getting worst as time goes by
List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited:		
1) 2) 3) 4)		
List the three main "health goals" that you would like to accomplish:		
1)		
2)		
3)		

HOW DID YOU HEAR ABOUT OUR OFFICE?_____.

A. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
B. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature _____ Date _____

Knee Pain or Neuropathy Screening

Dear Patient,

Welcome to our office!

We are happy that you have chosen us for your care. Our office offers a wide variety of treatment procedures, and clinical diagnostic tests. The reason for this no charge screening is to properly evaluate your condition with the best of our abilities. Our practitioners will be happy to answer your questions as a courtesy to you. The screening that we are offering you, although limited in time, will permit you, the patient, and our practitioners to better determine a definite treatment plan for your condition. Please understand that this no charge screening is only meant for you and us to better understand your health care needs. Nova IH offers a wide spectrum of health services namely: nutrition, therapeutic knee injections, neuropathy treatments, trigger point injections, headache treatments, and aesthetics. This clinic is very special in its nature, for it brings multiple treatments together. This wonderful combination allows us to effectively find the best treatment for your condition in the most natural manner. Our staff is very dedicated and extremely well versed in this subject. Should you decide to receive treatment today necessary payment arrangement can be set up for your convenience. Thank you for allowing us the privilege to treat you.

Sincerely,

Nova IH Staff

_____ _____

Patient Name Signature