Dr. John E. Upledger Foundation - Veterans Therapy Program Application

Please complete and return by email, fax, or mail to: The Dr. John E. Upledger Foundation
11211 Prosperity Farms Road, D-223, Palm Beach Gardens, FL 33410
Ph: 561.622.4588 Email: info@upledger.org Fax: 561.622.4771

Today's Date: _____

Name: _____ Date of Birth: ____/____/____ Age: ____ Male/Female

Address: _____City_____State_____Zip_____

E-mail Address: _____ Cell Phone #: (_____) _____-_____

Local Palm Beach Florida Home/Hotel Ph# _____

Emergency Contact Name and Phone#:_____

Employer:_____ Occupation:_____

Have you received CranioSacral Therapy? Y / N If so, who is your ongoing CST Therapist?

_____

Are you a Veteran of the U.S Military? Y / N If so, what branch? _____

_____

How many years did you serve? _____

Are you currently on active duty? Y / N If so, what branch? _____

_____

Do you currently have a medical diagnosis of Post Traumatic Stress Disorder (PTSD)? Y / N

Other Diagnosis(s)/ Conditions: _____

_____

1. Briefly describe your present injury, diagnosis, condition, or symptoms that you are seeking help for.

Primary concern/ major complaint: _____

_____

Other concerns/complaints: _____

_____

2. Was the onset: _____ sudden _____ gradual _____ related to accident or trauma
3. When did you first notice major complaints?

_____

_____

_____

4. What brought it on?

_____

_____

5. Describe your pain:

_____

_____

6. Has your pain changed in frequency, severity, or character since the onset?

_____

_____

7. Has the pain spread to other areas, or is it localized? _____
8. Is it constant or intermittent?

_____

9. Are you experiencing - pins and needles/ numbness/ burning (Please circle all that apply)
10. On a pain scale of 0 = none to 10 = unbearable

On a Good Day _____ On a Bad Day_____ Today_____

11. Please describe any weakness you are experiencing: _____

_____

12. Please mark an "**A**" for activities that **A**ggravate or worsen your symptoms and an "**R**" for those that help to **R**elieve or make them feel better

Standing	_____	Carrying	_____	Sneezing	_____
Sitting	_____	Laying Down	_____	Rising from chair	_____
Walking	_____	Lifting	_____	Rising from bed	_____
Deep Breathing	_____	Turning	_____	Other	_____
Twisting	_____	Coughing	_____	Other	_____

What do you do to provide relief? _____

13. Please describe how this condition is affecting:

Work: _____

Sleep: _____

Functional Mobility *(walking, bed mobility, transfers, driving, etc)*

_____

_____

Activities of Daily Living /Self-Care:_____

_____

Other activities: _____

_____

What was your level of functioning in these areas prior to the onset of your condition?

_____

14. What do you believe is causing, contributing to, or maintaining your condition? _____

15. Please describe any previous treatment you have had for this condition: _____

16. Has there been a medical diagnosis? Y / N

Diagnosis: _____

By whom: _____

17. How many physicians have treated you for this condition?

_____

18. Have you had recent x-rays or MRI's: Y / N

*Please attach copies of **recent reports** only if possible)*

19. Are you taking any of the following? Circle all that apply

Aspirins	Anti-depressants	Diet Supplements	Sleeping Pills	Vitamins
Laxatives	Insulin	Sedatives	Hormones	Herbs

20. Please list any medication you are currently taking: _____

_____

___ **Past Medical History:**

21. Have you ever been diagnosed with a heart condition, diabetes or cancer? If so, please describe:

22. Describe if you have experienced any of the following in addition to those previously mentioned:

Broken bones _____

Vehicle accidents _____

Other accidents: _____

Whiplash: _____

Falling on tailbone: _____

Major illnesses/ immune disorders: _____

Surgical procedures* _____ *

Please include tonsil removal, wisdom tooth removal, plastic surgery, breast augmentation, etc.

Other hospitalizations: _____

Dental History

Braces? Y/ N How long? _____ What age? _____

Root canals? Y/ N If so, how many? _____

Mercury fillings? Y/ N Were they removed? Y/ N

Do you have: dentures, bridges, any other dental appliances? _____

Social History:

23. Please check your level of daily intake for the following

Item	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Water	_____	_____	_____	_____

24. Please briefly describe your exercise routine _____

_____

___

25. Do you sleep on your: side _____ stomach _____ back _____

26. How many pillows do you use under your: head/neck _____Elsewhere_____

28. Which is your dominant hand, left or right _____

29. Do you carry a wallet in your back pocket- left or right _____

30. Which shoulder do you carry a purse on, left or right _____

31. Do you live with anyone? _____

32. Do you have anyone dependent on you for care? _____

Are you dependent on anyone for care? _____

33. How many stairs in your home _____at entrance of home_____ railings? _____

34. If applicable, how many pregnancies_____ births_____ were they difficult? If so, please describe:

_____

_____

35. Please identify any significant illnesses/ conditions/ circumstances regarding family medical history:

_____

_____

36. What are your hobbies/ what do you enjoy doing recreationally? How is your condition affecting these?

_____

___ ***Please help us be aware of any of the following precautions:***

Are you pregnant? _____

Range of motion restrictions/ activity limitations: _____

Implantation of medical/ dental devices *(cardiovascular, catheters, medicine pumps, IUD, shunts, dentures, other)*: _____

Swallowing/ food precautions: _____

Breathing/ suctioning: _____

Positioning issues: _____

Latex allergies: _____

Is there any concern regarding a change in Intracranial Pressure? Y / N

Other: _____

_____

What are your goals for treatment? _____

_____

_____

_____

What would you like to do that you are currently having difficulty with / unable to do?

_____

_____

_____

Is there anything you feel we should know to create the most beneficial environment for you? _____

_____

_____

_____

If your current condition is related to a traumatic event or accident please complete the following:

Please describe the significant details regarding how your injury/ accident / trauma occurred: _____

_____

_____

Was emergency care provided at the scene? Y / N

If not, when/ where did you seek medical care? _____

Was there a loss of consciousness at the time? Y / N If yes, how long? _____

Did you sustain a spinal cord injury? Y / N If yes, what level? _____

Is the Classification: Complete/ Incomplete Anterior Cord Central Cord Brown-Sequard

Other: _____

Please list significant details regarding hospital stay:

How long were you in inpatient acute care? _____ Inpatient rehab? _____

Was intubation / ventilator required? Y / N

Did you have any broken bones? Y / N

Please list surgeries that were performed and when: _____

_____

Were you discharged home with home therapies or outpatient services? _____

_____

Are you currently receiving therapies?

PT: _____ OT: _____

OT: _____

Other: _____

Please circle all symptoms you have difficulty with, and note specific areas as appropriate

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Arthritis
Asthma
Anemia
Atrophy
Aneurysm
Bowel/Bladder issues
Blood Pressure- Low / High
Balance problems
Cardiovascular disease
Constipation
Chest pain
Cold hands / feet
Cold sweats
Cognitive changes
Coordination/ Motor planning
Diarrhea
Dizziness
Developmental delays
Depression
Disc Bulge / Herniation
Edema / Swelling
Emotional Status
Face Flushed
Fainting
Fatigue
Grating in Neck
Gallbladder issues
Gas

Hearing
Heart pain or palpitations
Hay Fever
Head feels heavy
Hernia
Intestinal disorders
Immune deficiencies
Inner tension
Irritability
Loss of Smell
Loss of Taste sensations
Low Back or Sacroiliac Pain
Memory changes
Muscle Spasm / Cramping
Mood Swings
Muscle tone
Night sweats
Neuritis/ Neuralgia
Nervousness
Neuromuscular disease
Neurological trauma or disease Neck Pain
Numbness
Nystagmus
Oral - Motor dysfunction
Painful joints or extremities
Pinched nerves
Paralysis Perspiration- excessive or diminished
Pins and Needles feeling
Rheumatism
Rib Pain
Sciatica
Sensory Integration Issues
Sensory Changes
Scoliosis
Sinus pain / infections
Speech/ Communication
Swallowing difficulties
Stress
Spondylosis
Spondylolisthesis
Shortness of breath
Strabysmus (lazy eye/ eyes crossing) T.B.
Twitching
Tone Changes
Tremors
Ulcers
Vertigo
Vestibular dysfunction
Visual deficits / sensitivities

Female Only

Easily fatigued
Premenstrual mood swings
Excessive/prolonged
Menstrual cycle
Painful Breasts
Menopausal hot flashes
Vaginal discharge
Painful menstrual cramps
Birth Control Pills
Scant/missing menstrual cycle
Breast Implants
Melancholia/Depression
Hysterectomy

Male Only

Prostate trouble
Frequent night urination
Diminished sex drive
Pain with orgasm
Pain in groin area

Burning with urination
Persistent abdominal pain
Urination difficulty or dribbling
Tire easily

Lack of energy

Do you have Health Insurance? Y / N

Provider:_____

Do you have Medicaid or Medicare? (Circle One)

Thank you for choosing the Upledger Institute Clinic. We hope to facilitate your healing process soon. Once your application is received, you will be notified and given an update on program information.

"Post - Traumatic Stress Disorder is not an incurable, hopeless mental disorder. PTSD has been shown to have physical roots. I hope you will join us in the years to come as we seek to eliminate PTSD from the trauma equation."- Dr. John E. Upledger