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-325, 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 Aggravate or worsen your symptoms and an "R" for those that help to Relieve 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* _____

Other hospitalizations: _____

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

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

Arthritis	Gas	Pinched nerves
Asthma	Hearing	Paralysis
Anemia	Heart pain or palpitations	Perspiration-excessive or diminished
Atrophy	Hay Fever	Pins and Needles feeling
Aneurysm	Head feels heavy	Rheumatism
Bowel/Bladder issues	Hernia	Rib Pain
Blood Pressure - Low / High	Intestinal disorders	Sciatica
Balance problems	Immune deficiencies	Sensory Integration Issues
Cardiovascular disease	Inner tension	Sensory Changes
Constipation	Irritability	Scoliosis
Chest pain	Loss of Smell	Sinus pain / infections
Cold hands / feet	Loss of Taste sensations	Speech/ Communication
Cold sweats	Low Back or Sacroiliac Pain	Swallowing difficulties
Cognitive changes	Memory changes	Stress
Coordination/ Motor planning	Muscle Spasm / Cramping	Spondylosis
Diarrhea	Mood Swings	Spondylolisthesis
Dizziness	Muscle tone	Shortness of breath
Developmental delays	Night sweats	Strabysmus (lazy eye/ eyes crossing)
Depression	Neuritis/ Neuralgia	T.B.
Disc Bulge / Herniation	Nervousness	Twitching
Edema / Swelling	Neuromuscular disease	Tone Changes
Emotional Status	Neurological trauma or disease	Tremors
Face Flushed	Neck Pain	Ulcers
Fainting	Numbness	Vertigo
Fatigue	Nystagmus	Vestibular dysfunction
Grating in Neck	Oral - Motor dysfunction	Visual deficits / sensitivities
Gallbladder issues	Painful joints or extremities	

Female Only

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

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