INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Prefer to be called _____ Phone _____

Social Security Number _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Your Employer _____ Occupation _____ Years On Job _____

Do you have Medicare? Yes ____ No ____ Name of Parent/Guardian (**For Minors Only**) _____

How did you hear about our office: _____

Would you like appointment reminders? □ Via Email Address □ Via Cell Phone – Cell Carrier: _____

List any **Allergies**:

☐ Animals ☐ Aspirin ☐ Bees ☐ Chocolate ☐ Dairy ☐ Dust ☐ Eggs ☐ Latex ☐ Molds ☐ Penicillin ☐ Ragweed/Pollen
☐ Rubber ☐ Seasonal Allergies ☐ Shellfish ☐ Soaps ☐ Wheat ☐ Other:_____

List any **Surgeries**:

☐ Back ☐ Brain ☐ Elbow ☐ Foot ☐ Hip ☐ Knee ☐ Neck ☐ Neurological ☐ Shoulder ☐ Wrist ☐ Other:_____

List **ALL Past Medical History** conditions

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones ☐ Cancer ☐ Chest Pain ☐ Depression ☐ Diabetes
☐ Dizziness ☐ Elbow Pain ☐ Epilepsy ☐ Eye/Vision Problems ☐ Fainting ☐ Fatigue ☐ Foot Pain ☐ Genetic Spinal Condition
☐ Hand Pain ☐ Headaches ☐ Hearing Problems ☐ Hepatitis ☐ High Blood Pressure ☐ Hip Pain ☐ HIV ☐ Jaw Pain
☐ Joint Stiffness ☐ Knee Pain ☐ Leg Pain ☐ Menstrual Problems ☐ Mid-Back Pain ☐ Minor Heart Problem ☐ Multiple Sclerosis
☐ Neck Pain ☐ Neurological Problems ☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Shoulder Pain
☐ Significant Weight Change ☐ Spinal Cord Injury ☐ Sprain/ Strain ☐ Stroke/Heart Attack ☐ Other: _____

Are you currently taking any medications (including regularly taken over the counter medications)?

☐ Check this box if you are not taking any medications.

Medication Name		
1.	4.	7.
2.	5.	8.
3.	6.	9.

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes ☐ Epilepsy ☐ Genetic Spinal Condition
☐ High Blood Pressure ☐ Heart Problem ☐ Multiple Sclerosis ☐ Neurological Problems ☐ Parkinson's ☐ Polio ☐ Prostate Problems ☐ Stroke/Heart Attack ☐ Other: _____

Is your condition due to an accident? Yes ____ No ____ Date of accident? _____

Type of accident? _____

Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

Notice to our new patients: *Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.*

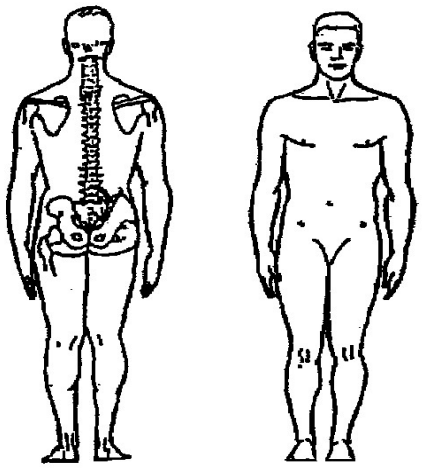
Smoker Status: ___ Smoke Daily ___ Smokes Often ___ Former Smoker ___ Never Smoked

Do you drink alcohol? ☐ No ☐ Yes Drinks/Day: _____ Do you drink caffeine ☐ No ☐ Yes – Drinks/Day:_____

Have you missed work or school as a result of your injuries? YES NO

WOMEN ONLY: Are you currently pregnant or is there any possibility you may be pregnant? YES NO _____ Initials

PATIENT CONDITION FORM



PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM.

Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce Symptoms
- Resume normal activity level

Major Complaint? _____

Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES NO Location of pain: Left Right Center Both Sides

Please rate your pain from 0-10 (0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: Minimum Mild Moderate Severe Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the nature of your symptoms: ☐ Burning ☐ Dull ☐ Numb ☐ Radiating Pain (_____)

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Numbness ☐ Loss of Strength

☐ Other: _____

What makes it worse? _____

What makes it better?_____

How Often do you experience symptoms?

☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

Patient's Signature: _____ Date: _____/_____/_____

What is your **second** complaint? _____Date problem began?_____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you had this condition in the past? YES NO Location of pain: Left Right Center Both Sides

Please rate your pain from 0-10 (0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Intensity: Minimum Mild Moderate Severe Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe the nature of your symptoms: ☐ Burning ☐ Dull ☐ Numb ☐ Radiating Pain (_____)

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Numbness ☐ Loss of Strength

☐ Other: _____

What makes it worse? _____

What makes it better?_____

How Often do you experience symptoms?

☐ Constantly (76-100% of day) ☐ Frequently (51-75% of day) ☐ Occasionally (26-50% of day) ☐ Intermittently (0-25% of day)

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Respiratory (Breathing) ☐ Mouth (Taste)

☐ Bladder ☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite

What type of changes are you experiencing: _____

_____

Have you ever had chiropractic care? _____

When? _____ Why? _____

Where? _____

Were X-rays taken? _____

When was your last adjustment? _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Guardian Signature (if applicable) _____ Date _____

Patient's Signature: _____ Date: _____/_____/_____