Whom may we thank for referring you to this office → ______________________________?

APPLICATION FOR CARE AT Accurso Chiropractic Center

Today's Date: ________________ HRN: _____________________

PATIENT DEMOGRAPHICS

Name__________________________ Birth Date: ____-____-____ Age: ___ ☐ Male ☐ Female

Address: ______________________________ City: ___________________ State: ____ Zip: _________

E-mail Address: ______________________Home Phone: ____________Mobile Phone:_____________

Marital Status: ❑Single ❑Married Do you have Insurance: ❑Yes ❑No Work Phone: _____________

Social Security #: ________________ Driver's License #: _____________________________________

Employer: ________________________ Occupation: _______________________________________

Spouse's Name ____________________________Spouse's Employer ___________________________

Number of children and Ages: ______________________________

Name & Number of Emergency Contact: ________________________Relationship: _______________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: ______________________

Secondarily: ____________________ Third: ______________________ Fourth: __________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number***:

Primary or chief complaint is 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint is: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _______

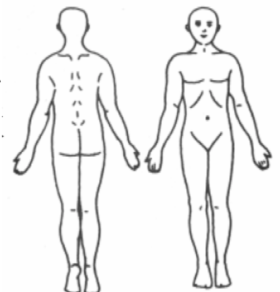
When is the problem at its worst? ☐ AM ☐PM ☐mid-day ☐late PM

How long does it last? ☐ It is constant **OR**☐ I experience it on and off during the day **OR**☐ It comes and goes throughout the week **How did the injury happen?_________________________**

Condition(s) ever been treated by anyone in the past? ☐No☐Yes **If yes,** when: ______ by whom? _____________________________

How long were you under care: ____ What were the results? ____

Name of Previous Chiropractor: _________________________________ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B= B**urning **D =D**ull **A =** Aching **N = N**umbness **S =S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____________________________

What makes them feel worse? ___________________________________

Is your problem the result of ANY type of accident? ❑ Yes, ❑ No

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? ______ When was the last episode? __________ How did the injury happen?____________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED
BY WHOM		
INJURIES →		
SURGERIES →		
CHILDHOOD DISEASES→		
ADULT DISEASES →		

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes →How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occurs→❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom:❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ___________________________

Please list the **3 Most Important People/Things** in your life: 1. ______________________
2. ________________________ 3.________________________

I hereby authorize payment to be made directly to Brain to Body Chiropractic, Inc 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 Accurso Chiropractic for any and all services I receive at this office.

_____________________________________ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____________________________________ _______ - _______ - ______

Doctor's Signature **Date Form Reviewed**

Activities of Daily Living/Symptoms/Medications

Patient Name: ____________________________________ File#____________ **Date:** _____________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Patient Name______________________________________ File#/HRN _____________Date________

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache
___ Neck Pain
___ Jaw Pain, TMJ
___ Shoulder Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain
___ Back Curvature
___ Scoliosis
___ Numb/Tingling arm, hand, finger
___ Numb/Tingling legs, feet, toes
___ Foot/Knee Problems
___ Swollen/Painful Joints
___ Skin Problems

___ Pregnant (Now)
___ Frequent Colds/Flu
___ Convulsions/Epilepsy
___ Tremors
___ Blurred Vision
___ Pain w/Cough/Sneeze
___ Sinus/Drainage Problem
___ Allergies
___ Difficulty Breathing
___ Asthma
___ Learning Disability
___ ADD/ADHD
___ Eating Disorder
___ Trouble Sleeping

___ Dizziness
___ Loss of Balance
___ Digestive Problems
___ Double Vision
___ Diarrhea/Constipation
___ Ringing in Ears
___ PMS
___ Menstrual Problem
___ Menopausal Problems
___ Depression
___ Irritable
___ Mood Changes
___ Impotence/Sexual Dysfun.
___ Fainting

___ Prostate Problems
___ Chest Pain
___ Heart Problem
___ High Blood Pressure
___ Low Blood Pressure
___ Heartburn
___ Hearing Loss
___ Lung Problems
___ Bed Wetting
___ Ulcers
___ Kidney Trouble
___ Gall Bladder Trouble
___ Liver Trouble
___ Hepatitis (A,B,C)
___ Colon Trouble

List Prescription & Non-Prescription drugs you take:____
____
____

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ____

What speed was the collision? ____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe ______________________________________

When was your most recent strain / stress at work? ______________________________________

Please describe the manner of the injury ____

Was treatment received? Please describe _______________________________________

Does your job require you remain in long term stressful postures?____________________

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? ____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field____

Trauma as a child! i.e. fall on your head, impact to your head, concussion,
fall onto your back or tailbone, biking accident____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

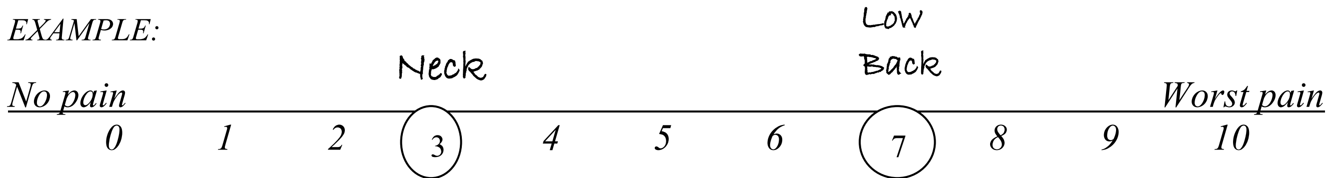
Accurso Chiropractic Center

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) **Pt #________________**

Patient Name: ________________________________ Date: __________________

Please circle the number that best describes the question asked.
If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:



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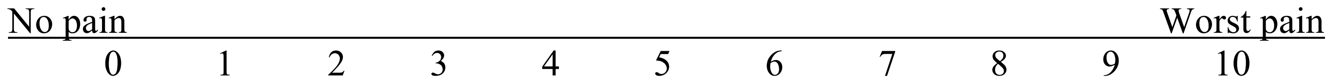
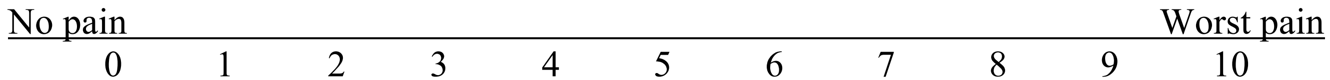
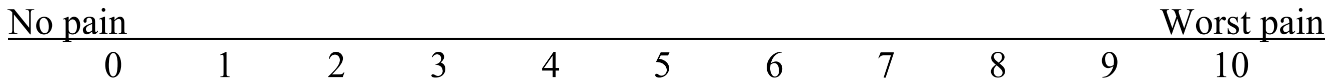
1. How would you rate your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

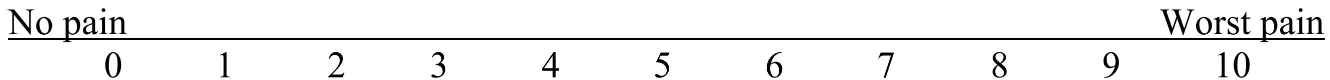


3. What is your pain level AT ITS BEST? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST? (How close to 10 does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst?____%

Score________

Brain to Body Chiropractic, Inc ● 6030 Bird Road Miami, FL 33155 ● 305-337-1188 ● Fax 305-667-1669