

## Application for Care at Major Family Chiropractic

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_

- Male  
 Female  
 Other

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 **circling the number**:

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

**Second** complaints 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

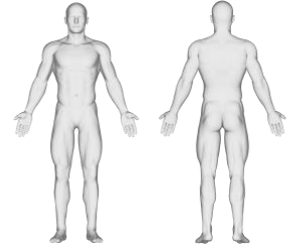
How long does it last?  It is constant **OR**  I experience it on and off during the day **OR**  It comes and goes throughout the week

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** = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

What relieves your symptoms? \_\_\_\_\_  
 What makes them feel worse? \_\_\_\_\_

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

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

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_

\_\_\_\_\_

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past?  No  Yes **If yes** how many times? \_\_\_\_\_

Other forms of treatment tried:  No  Yes If yes, please state what type of treatment: \_\_\_\_\_,  
 and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results?  Favorable  
 Unfavorable Please explain: \_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

\_\_\_\_\_

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the Past, **C** for Currently have or **N** for Never have had:

- Broken Bone     Dislocations     Tumors     Rheumatoid Arthritis     Fracture     Disability     Cancer  
 Heart Attack     Osteo Arthritis     Diabetes     Cerebral Vascular     Other serious conditions:

**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: \_\_\_\_\_

I hereby authorize payment to be made directly to [this office](#) for 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 [this office](#) for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

Patient's Name: \_\_\_\_\_ HR#: \_\_\_\_\_ / /

Patient Name \_\_\_\_\_

File#/HRN \_\_\_\_\_

Date \_\_\_\_\_

**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 sitting, 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”

**INITIAL NUTRITIONAL PROFILE**

Have you tested with high triglycerides or high cholesterol? ( Y/ N) Values? \_\_\_\_\_

Have you tested with high blood pressure? ( Y/ N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? ( Y/ N)

Do you eat breakfast daily from Monday to Friday? ( Y/ N) \_\_\_\_\_

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or prepared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda    Coffee    Juice    Milk    Soda    Alcohol

Please list any supplements you take regularly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INITIAL FITNESS PROFILE**

How many times per week do you exercise?

Cardiovascular\_\_\_\_Hours\_\_\_\_Days/Wk                      Weight Training\_\_\_\_Hours\_\_\_\_Days/Wk

Low Impact (Yoga, etc.)\_\_\_\_Hours\_\_\_\_Days/Wk

What is your target weight?\_\_\_\_\_What is your current weight? \_\_\_\_\_

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) \_\_\_\_\_

**INITIAL TOXICITY PROFILE**

Are you regularly exposed to cleaning products or industrial chemicals? ( Y/ N)

Have you ever noticed mold growing in your home or your place of work? ( Y/ N)

Does your home, work, school, or car have a damp or mildew smell? ( Y/ N)

Have you received a full standard profile of vaccinations? ( Y/ N)

Do you receive yearly flu shots? ( Y/ N) How many flu shots have you received?\_\_\_\_\_ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? ( Y/ N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ( Y/ N)

**INITIAL STRESS PROFILE**

Do you get an average of 8 hours of sleep per night? ( Y/ N)

Do you average less than 7 hours of sleep per night? ( Y/ N)

Do you ever take pills to go to sleep or relax? ( Y/ N)

Do you often feel short on time and procrastinate on projects? ( Y/ N)

Do you experience feelings of anxiety about completing tasks? ( Y/ N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? ( Y/ N)

Do you rely more on your memory than a planner and action list to get things done? ( Y/ N)

Do you take time to pray, meditate, or visualize on a regular basis? ( Y/ N)

## Activities of Daily Living/Symptoms/Medications

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ File# \_\_\_\_\_

### 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:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

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

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems     | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Digestive Problems   |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Colon Trouble         | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Menopausal Problems   | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menstrual Problem     | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> PMS                   | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Learning Disability   | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Trouble Sleeping      | <input type="checkbox"/> Hepatitis (A, B, C)  |
| <input type="checkbox"/> Impotence/Sexual Dysfunction       |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Ulcers                |   |

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>	
I have reviewed the above ADL & ROS Form with the above named patient:	
_____ Doctor Signature	_____ Date

**INFORMED CONSENT**

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at \_\_\_\_\_ Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_       Witness Initials  
Patient or Authorized person's Signature      Date

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY:** please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on\_\_\_\_/\_\_\_\_/\_\_\_\_ Date

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_       Witness Initials  
Patient or Authorized person's Signature      Date