# **Application for Care at** Premier 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

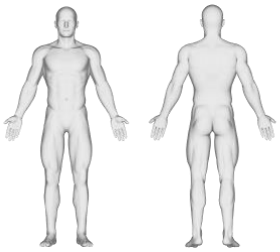
How long does it last? ☐ It is constant **OR** ☐I experience it on and off during the day **OR** ☐It comes and goes throughout the week

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? (O Y/ O N)

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

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

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

Do you receive yearly flu shots? ( O Y/ O 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? (O Y/ O N)

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

## INITIAL STRESS PROFILE

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

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

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

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

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

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

Do you take time to pray, meditate, or visualize on a regular basis? (O Y / O 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 | ☐ 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 |

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

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

List Prescription & Non-Prescription drugs you take:_____

_____

_____

FOR OFFICE USE ONLY
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