Application for Care at Beard Family Chiropractic

Today's Date ____________ **HRN** ____________ **How did you hear about us?** ____________

PATIENT DEMOGRAPHICS

Name ____________ **How would you like to be addressed?** ____________

Birth Date ____________ **Gender** ____________ **Age** ____________

Address ____________

City ____________ **State** ____________ **Zip** ____________

Email ____________ **Mobile Phone** ____________

Marital Status
☐ Married ☐ Single ☐ Widowed

Do you have Insurance
☐ Yes ☐ No

Insurance Company ____________

Employer ____________ **Occupation** ____________

Spouse's Name ____________ **Spouse's Employer** ____________

Number of children and Ages ____________

Name & Number of Emergency Contact ____________ **Relationship** ____________

What goal do you have for your health and your care here? ____________

History Of Complaint

Please identify the condition(s) that brought you into this office:

Primarily

Secondarily

Third

Fourth

Primary or chief complaint is (0=not bothersome, 10=debilitating)

- (●) 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 is

- (●) 0
- ( ) 1
- ( ) 2
- ( ) 3
- ( ) 4
- ( ) 5
- ( ) 6
- ( ) 7
- ( ) 8
- ( ) 9
- ( ) 10

Fourth complaint is

- (●) 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?

- [ ] Is it constant
- [ ] I experience it on and off during the day
- [ ] It comes and goes throughout the week

Condition(s) ever been treated by anyone in the past?

- [ ] Yes
- [ ] No

If yes, when

---

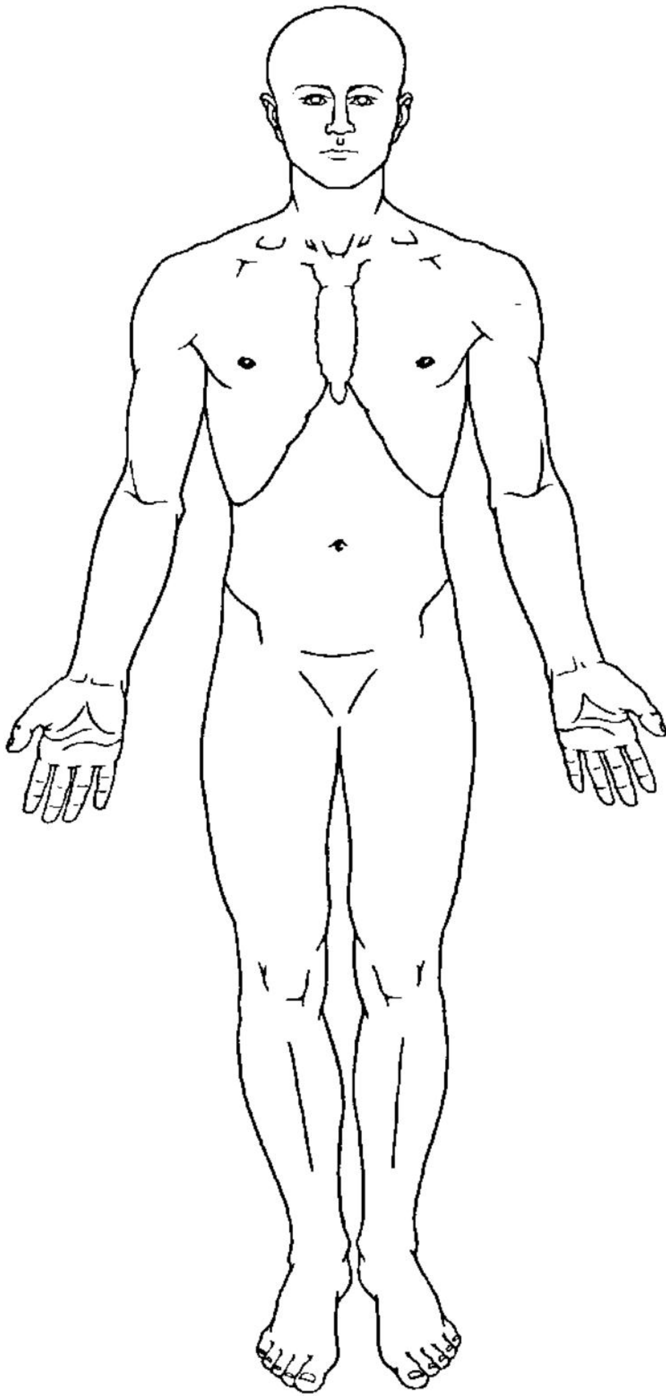
by whom?

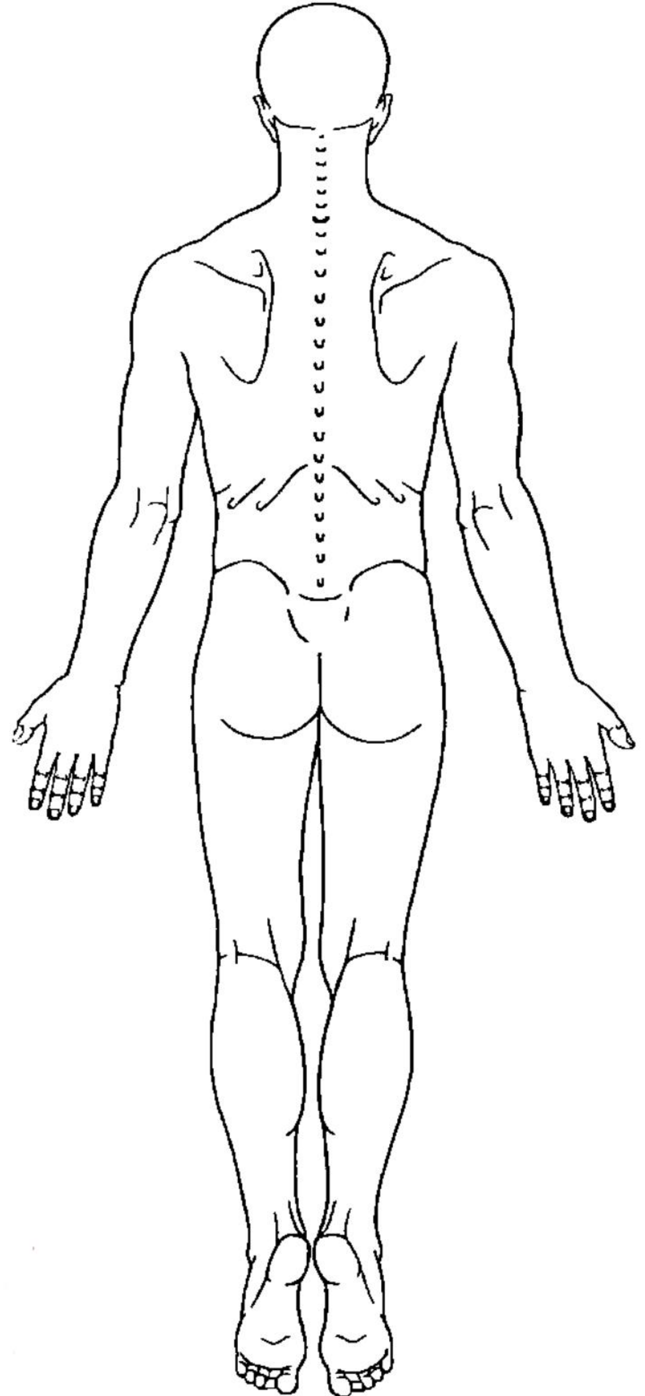
How long were you under care

What were the results?

Name of Previous Chiropractor, If Applicable

Please mark your problem the areas on the diagram with an X. If no pain, mark off the diagram





Your pain is:

- ☐ Radiating
- ☐ Aching
- ☐ Tingling
- ☐ Burning
- ☐ Numbness
- ☐ None of these
- ☐ Dull
- ☐ Sharp/Stabbing

Patient's Name ______________________ **HR#** ______________________ **Date** ______________________

What relieves your symptoms?

What makes them feel worse?

List restricted activity (example. Sleep)

Current Ability to Do Activity Above (Ex: 4 hours without pain)

Usual or Desired Ability (ex. 8 hours straight)

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 ever been in an auto accident?

- [ ] Yes
- [ ] No

When? Please briefly describe what happened and injuries.

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

Please indicate if you have been diagnosed with any of the following conditions

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

PLEASE Identify ALL PAST and any CURRENT conditions or injuries:

Injuries

How long ago?

Did you receive care for the injury(s)? Describe if so.

Surgeries

How long ago?

Childhood or Adult Diseases

Have you tried any treatments for this?

SOCIAL HISTORY

Smoking

- ☐ Cigars
- ☐ Pipe
- ☐ Cigarettes
- ☐ Marijuana

How often?

- ☐ Daily
- ☐ Weekends
- ☐ Occasionally
- ☐ Never

Recreational Drug Use

- ☐ Daily
- ☐ Weekends
- ☐ Occasionally
- ☐ Never

Alcoholic Beverage: Consumption Occurs

- ☐ Daily
- ☐ Weekends
- ☐ Occasionally
- ☐ Never

How many times per week do you exercise?

- ☑ 0
- ☐ 1-3
- ☐ 4-5
- ☐ 6+

What do you do for exercise?

____

FAMILY HISTORY

Does anyone in your family suffer the same condition(s)?

- ☐ Yes
- ☐ No

If yes, Whom

- ☐ Grandmother
- ☐ Grandfather
- ☐ Mother
- ☐ Father
- ☐ Sister(s)
- ☐ Brother(s)
- ☐ Son(s)
- ☐ Daughter(s)

Any other hereditary conditions the doctor should be aware of?

- ☐ Yes
- ☐ No

If yes, Please explain

____

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

Doing computer Work

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Preform

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

Carrying

- ☐ 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

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

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

Walking

- [ ] No Effect
- [ ] Painful (can do)
- [ ] Painful (limits)
- [ ] Unable to Perform

Please mark anything you are experiencing or have experiences in the past 6 months

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

Females: Do you have irregular cycles?

- [ ] Yes
- [ ] No

How many days is your typical cycle, from Day 1 of menstruation until the next menstruation?

____

Are you currently pregnant?

- [ ] Yes
- [ ] No
- [ ] Trying to conceive

List Prescription & Non-Prescription drugs you take, and for what conditition. If none, write

____

Please list any supplements you are currently taking

____

Name of patient

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, 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 (insert practice name) 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.

Signature

Date Signed

Printed Name

Email

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.

Signature

Date Signed

Printed Name

Email

The first day of my last menstrual cycle was on

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

◯ Yes

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

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