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

APPLICATION FOR CARE AT Lane Avenue Chiropractic

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone _____ Mobile Phone_____ Cell Carrier _____
Okay to text? ☐ Yes ☐ No

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:

Primary or chief complaint is : _____

Second complaints is

Third complaint:

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

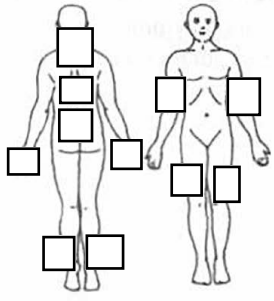
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes,** when: _____ by whom? _____ ___
What were the results? _____

How long were you under care: _____ ___

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



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

Check areas that either have PAIN or NUMBNESS

What relieves your symptoms? _____

What makes them feel worse? _____

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

List any medications you currently take:

_____

_____

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? _____

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 and **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
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

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s) ☐ No ☐ Yes
If yes whom:
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 Lane Avenue Chiropractic, 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 Lane Avenue 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**

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Point Scale: Check the box if you ever have:

HEAD	☐	Headaches
	☐	Faintness
	☐	Dizziness
	☐	Insomnia **TOTAL** _____
EYES	☐	Watery or itchy eyes
	☐	Swollen, reddened or sticky eyelids
	☐	Bags or dark circles under eyes
	☐	Blurred or tunnel vision **TOTAL** _____
EARS	☐	Itchy ears
	☐	Earaches, ear infections
	☐	Drainage from ear
	☐	Ringing in ears, hearing loss **TOTAL** _____
NOSE	☐	Stuffy nose
	☐	Sinus problems
	☐	Hay fever
	☐	Sneezing attacks
	☐	Excessive mucus formation **TOTAL** _____
MOUTH/ THROAT	☐	Chronic coughing
	☐	Gagging, frequent need to clear throat
	☐	Sore throat, hoarseness, loss of voice
	☐	Swollen or discolored tongue, gums, lips
	☐	Canker sores **TOTAL** _____
SKIN	☐	Acne
	☐	Hives, rashes, dry skin
	☐	Hair loss
	☐	Flushing, hot flashes
	☐	Excessive sweating **TOTAL** _____
HEART	☐	Chest pain
	☐	Irregular or skipped heartbeat
	☐	Rapid or pounding heartbeat **TOTAL** _____
LUNGS	☐	Chest congestion
	☐	Asthma, bronchitis
	☐	Shortness of breath
	☐	Difficulty breathing **TOTAL** _____
DIGESTIVE TRACT	☐	Nausea, vomiting
	☐	Diarrhea
	☐	Constipation
	☐	Bloated feeling
	☐	Belching, passing gas
	☐	Heartburn
	☐	Intestinal/stomach pain **TOTAL** _____
JOINTS/ MUSCLE	☐	Pain or aches in joints
	☐	Arthritis
	☐	Stiffness or limitation of movement
	☐	Feeling of weakness or tiredness
	☐	Pain or aches in muscles **TOTAL** _____
WEIGHT	☐	Binge eating/drinking
	☐	Craving certain foods
	☐	Excessive weight
	☐	Water retention
	☐	Underweight
	☐	Compulsive eating **TOTAL** _____
ENERGY/ ACTIVITY	☐	Fatigue, sluggishness
	☐	Apathy, lethargy
	☐	Hyperactivity
	☐	Restlessness **TOTAL** _____
MIND	☐	Poor memory
	☐	Confusion, poor comprehension
	☐	Difficulty in making decisions
	☐	Stuttering or stammering
	☐	Slurred speech
	☐	Learning disabilities
	☐	Poor concentration
	☐	Poor physical coordination **TOTAL** _____
EMOTIONS	☐	Mood swings
	☐	Anxiety, fear, nervousness
	☐	Anger, irritability, aggressiveness
	☐	Depression
	☐	Slurred speech **TOTAL** _____
OTHER	☐	Frequent illness
	☐	Frequent or urgent urination
	☐	Genital itch or discharge **TOTAL** _____
GRAND TOTAL		**TOTAL** _____