***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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**C**ondition(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:

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

**Low Back**

*EXAMPLE:*

**Neck**

*No pain Worst pain*

*0 1 2 3 4 5 6 7 8 9 10*

------------------------------------------------------------------------------------------------------------

1. How would you rate your pain RIGHT NOW?

No pain Worst pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No pain Worst pain

0 1 2 3 4 5 6 7 8 9 10

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

No pain Worst pain

0 1 2 3 4 5 6 7 8 9 10

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?)

No pain Worst pain

0 1 2 3 4 5 6 7 8 9 10

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

Score\_\_\_\_\_\_\_\_