Application for Care at

East Coast Family

Chiropractic

Today's Date:_____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____-_____-_____ Age: _____ Gender: _____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed 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: Primary: _____

Secondary:_____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 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? ☐ 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**

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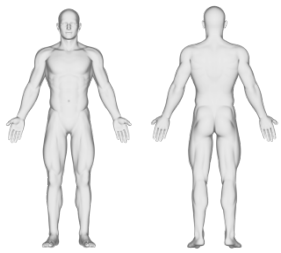

***PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

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? _____
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 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:

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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 Name Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ HRN:_____

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

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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	___Legs and Feet

List Prescription & Non-Prescription drugs you take:_____

_____

_____

_____

_____

How did you hear about us?

_____

_____

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 **East Coast Family 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