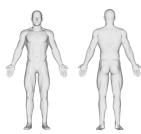
Application for Care at

Lakeview Family Chiropractic

Today's Date:						HRN:							
PATIENT DEMOGRAPHICS													
Name:						Birth	n Dat	e:				_ Age:	Gender:
Address:					(City:_						_State:	Zip:
	Home												
Marital Status: ☐ Single ☐ M	//arried	 	Vido	wed	Do v	ou h	ave lı	nsura	ınce:	□ Ye	es □ No	Work Pho	one:
							Driver's License #:						
Employer:													
Spouse's Name													
Number of children and Ages													
Name & Number of Emergen												Relati	ionship:
	ify the condition(s) that brought you to this office: F												
On a scale of 1 to 10 with 10	being t	he w	orst į	pain a	and z	ero b	eing ı	no pa	iin, ra	ite yo	ur abov	ve complain	its 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	?					_Whe	n is t	he pr	obler	n at i	ts worst	t? □AM □P	M □mid-day □late Рм How
long does it last? ☐ It is constarthe injury happen?				nce it (on an	d off o	during	the d	lay O l	R□l	t comes	and goes th	roughout the week How did
Condition(s) ever been treated	d by ar	nyone	in th	ne pa	st? □	No	□ Y	es If	yes, v	when	:	by who	m?
How long were you under car	e:				Wha	t were	e the	resu	lts? _				
Name of Previous Chiropracto													

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



R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing I = 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 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: How long ago? What were the results? 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 have or N for Never have had:	n the Past, C for Currently					
Broken BoneDislocationsTumorsRheumatoid ArthritisFracture	DisabilityCancer ous conditions:					

PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF	CARE F	RECEIVED	BY WHO	M
INJURIES						
SURGERIES						
CHILDHOOD DISEASES						
ADULT DISEASES						
SOCIAL HISTORY						
1. Smoking: □cigars □	pipe □cigarettes H	ow often?	□Daily	□Weekends	□Occasionally	□ Never
2. Alcoholic Beverage: cons			□Daily	□Weekends	□Occasionally	□Never
3. Recreational Drug use:			□Daily	□Weekends	□Occasionally	□Never
· ·					·	
FAMILY HISTORY:						
1. Does anyone in your fam If yes whom: □grandmo Have they ever been trea	other □grandfather □m	other □father	□sister(□son(s) □daughter(s)	
2. Any other hereditary con	ditions the doctor should	d be aware of?	'□No □Y	es:		
						•
I hereby authorize payment to other collateral sources. I auth payments, and further acknow remain financially responsible	rledge that this assignment	of benefits does	s not in anv	≀ wav relieve me c	der a healthcare plan or fro rocessing claims and effec f payment liability and that	om any sting I will
Patient or Authorized Person	on's Signature		Dat	 te Completed		
Doctor's Name			Dat	 te Form Reviewe	ed .	
Patient's Name:		HR#:			<u>' </u>	

Activities of Daily Living/Symptoms/Medications

Patient Name:		Date:		HRN:
	•	ects of Current conditi affecting your ability to carry		
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,		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					

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Lakeview Family Chiropractic

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

Lakeview 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 ne	ecessary to treat my condition at any time throughout the entire
clinical co	urse of my care.
Difference A the inches and Circuit as	/ Witness Initials
Patient or Authorized person's Signature Date	
REGARDING: X-rays/Imaging Studies	
FEMALES ONLY : please read carefully and check the boxe and have no further questions, otherwise see our receptionic	es, include the appropriate date, then sign below if you understand st 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 mo not pregnant.	st likely to become pregnant, and to the best of my knowledge, I am
effects of ionization to an unborn child, and I have conveyed	and or a member of the staff has discussed with me the hazardous d my understanding of the risks associated with exposure to x-rays. have the diagnostic x-ray examination the doctor has deemed
	/ Witness Initials
Patient or Authorized person's Signature Date	