# Application for Care at
MaxLiving Southside

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:**

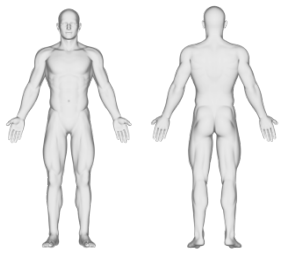
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Primary** or chief complaint is | : 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Second** complaints is | : 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Third** complaint is | : 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 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**



***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 MaxLiving Southside 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