



Application for Health



PRACTICE MEMBER INFORMATION

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		
CITY	STATE	ZIP CODE
BEST PHONE NUMBER TO REACH YOU	E-MAIL (FOR COMMUNICATING IMPORTANT HEALTH INFORMATION)	
YOUR EMPLOYER	YOUR OCCUPATION	
DATE OF BIRTH	AGE	SOCIAL SECURITY # (FOR INSURANCE)
	SEX	MARITAL STATUS
	M	F
NAMES AND AGES OF CHILDREN		

Scoliosis can be prevented or minimized if detected early enough. Would you like to receive complimentary scoliosis examinations for your children? Yes No

Will you be using health insurance to supplement payment to our office? Yes No
 If yes, please provide us with your insurance card and we'll make a copy. We will also verify your coverage.

Are you covered under someone else's insurance? Yes No Spouse Parent
 Enter their information below:

LAST NAME	FIRST NAME	M.I.
SOCIAL SECURITY # (FOR INSURANCE)	DATE OF BIRTH (FOR INSURANCE)	

Are you filing a worker's compensation claim? No Yes Date reported to employer: _____

Are you filing a personal injury claim? No Yes Attorney name: _____

We provide the following healthcare services. Check ALL the types of care that you are interested in receiving.

- Wellness Care:** I currently have no symptoms. My goal is to maintain the health of my spine and nervous system while preventing degenerative disease.
- Corrective Care:** My goal is to achieve natural symptom relief and to maximally improve my posture, spinal alignment, mobility, strength, nerve function and health.
- Rehabilitation Care:** My goal is to achieve natural symptoms relief and maximum healing of my injuries/tissue damage.
- Relief Care:** My goal is to achieve natural symptom relief without the dangerous side-effects of medications.

How did you find out about Family Chiropractic? _____
 Who may I thank for referring you to Family Chiropractic? _____

When was your last chiropractic visit? First time ___weeks ___months ___years
 What type of care? Corrective/Rehabilitative Symptom relief Wellness/Maintenance

Name: _____

Date: _____

✓ Check each of your health problems.

✓ Check which side of your body it is located.

At its worst, how severe is your health problem? (10 is the most severe) Circle the number.

What percentage of your waking day do you feel your health problems? (100% is constant)

HEAD PROBLEMS

- 1. Headaches or Migraines
- 2. TMJ (jaw) Pain/Clicking

SPINAL PROBLEMS

- 3. Neck Pain Stiffness
- 4. Upper Shoulder (trapezius) Pain
- 5. Upper Back (Shoulder blades) Pain
- 6. Middle Back Pain Stiffness
- 7. Low Back Pain Stiffness
- 8. Pelvis/Buttock Pain

UPPER EXTREMITY (ARM) PROBLEMS

- 9. Shoulder Joint Pain
- 10. Elbow Joint Pain
- 11. Wrist Pain
- 12. Hand Pain Numbness Tingling
- 13. Arm Pain Numbness Tingling

LOWER EXTREMITY (LEG) PROBLEMS

- 14. Hip Joint Pain
- 15. Knee Joint Pain
- 16. Ankle Joint Pain
- 17. Foot Pain Numbness Tingling
- 18. Leg Pain Numbness Tingling

CHEST, ABDOMINAL OR PELVIC PROBLEMS

- 19. Chest Pain/ Symptoms
- 20. Abdominal Pain/ Symptoms
- 21. Pelvic Pain/ Symptoms

WHICH SIDE?

- Left Both Right
- Left Both Right

WHICH SIDE?

- Left Both Right
- Left Both Right
- Left Both Right
- Left Both Right
- Left Both Right
- Left Both Right

WHICH SIDE?

- Left Both Right
- Left Both Right
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- Left Both Right

WHICH SIDE?

- Left Both Right
- Left Both Right
- Left Both Right
- Left Both Right
- Left Both Right

WHICH SIDE?

- Left Both Right
- Left Both Right
- Left Both Right

MILD	MODERATE	SEVERE
0	1	2
3	4	5
6	7	8
9	10	

MILD	MODERATE	SEVERE
0	1	2
3	4	5
6	7	8
9	10	

MILD	MODERATE	SEVERE
0	1	2
3	4	5
6	7	8
9	10	

MILD	MODERATE	SEVERE
0	1	2
3	4	5
6	7	8
9	10	

MILD	MODERATE	SEVERE
0	1	2
3	4	5
6	7	8
9	10	

OCCASIONAL	CONSTANT
0%	25%
50%	75%
100%	

OCCASIONAL	CONSTANT
0%	25%
50%	75%
100%	

OCCASIONAL	CONSTANT
0%	25%
50%	75%
100%	

OCCASIONAL	CONSTANT
0%	25%
50%	75%
100%	

OCCASIONAL	CONSTANT
0%	25%
50%	75%
100%	

Answer the following questions regarding your health problems:

Which health problem concerns you the most? _____

Describe your health problem: sharp dull ache burning radiating/spreading throbbing pinching twinge

Explain: _____

How many days out of the week do you experience you health problem? daily 6 5 4 3 2 1 day (s)

What time of the day is your health problem the worst? morning afternoon evening sleeping all day varies

How long have you been experiencing your health problem? ___ day(s) ___ week(s) ___ month(s) ___ year(s)

Have you experienced your current health problem in the past? No Yes, the last time was _____ ago.

What do you feel caused your health problem? I don't know injury auto accident stress developed over time

Explain: _____

What aggravates or makes you health problem worse? _____

What relieves or makes your health problems better? _____

Who have you seen previously for this health problem? No one Chiropractor Medical Physical Therapist

What treatment did you receive? _____

Which of the following activities of daily life are being adversely affected by your current health problem?

- Sitting Walking Climbing stairs Housework Job/Work
- Standing up Running Bending over Cooking Computer work
- Standing Exercising Sleeping Laundry Social life
- Laying on side L R Sports activities Lifting children Yard work Relationships
- Laying on back Relaxation Playing with kids Driving Finances

Other activities not listed: _____

Name: _____ Date: _____

PHYSICAL TRAUMA: List any significant physical traumas from birth to the present– include current (accidents, injuries, etc.): _____

EMOTIONAL TRAUMA: List any significant emotional traumas form birth to the present (deaths, divorce, etc.): _____

HOSPITAL: List any illnesses or conditions that required hospitalization or surgery: _____

DISEASE OR ILLNESS: List any diagnosed diseases or conditions (such as diabetes, allergies, asthma, etc): _____

FAMILY HEALTH HISTORY: List any significant health problems involving parents or siblings (cancer, heart disease, etc.): _____

MEDICATION: Are you currently taking any prescription or over the counter drugs? Yes No
List the medication and the condition you are taking it for: _____

Have you experienced side effects?: No Yes _____

STRESS: How would you rate your stress level? none mild moderate severe very severe

HABITS: Do you smoke? No Yes How many years? _____ How many per day? _____

Do you drink more than two servings of alcohol per day on a regular basis? No Yes

Do you drink caffeinated drinks? (coffee, tea, soda, etc.) No Yes How many cups per day? _____

Do you eat white sugar foods? (cookies, cakes, candy, etc.) No Yes How many servings per day? _____

PREGNANCY: Are you pregnant? Yes No Unsure If yes, how many weeks? ____ Due Date: _____

EXERCISE: Do you exercise? No Yes How many days per week? 1 2 3 4 5 6 7

Type of exercise? Cardio/Aerobics Weights Stretching Yoga Other: _____

NUTRITION: How would you describe your diet? poor fair good excellent

How many servings of fruits and vegetables do you consume on a daily basis? _____

List any nutritional supplements you are taking? _____

HEALTH: On a scale from 1 to 10, how would you rate your current state of health?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

FAILING

POOR

FAIR

GOOD

EXCELLENT

FITNESS: On a scale from 1 to 10, how would you grade your level of fitness (strength, endurance, etc.)?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

VERY POOR

POOR

FAIR

GOOD

EXCELLENT

COMMITMENT: On a scale from 1 to 10, how committed are you to regaining your health and fitness?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

NOT A PRIORITY

SLIGHTLY

MODERATELY

VERY

EXTREMELY

In the last 5 years has your health been: getting worse getting better staying the same

Do you base your health on how you feel (presence or absence of pain or symptoms) or do you base your health on scientific measurements of function such as lab and diagnostic tests? How I feel How I function

Patient Signature

Date

Name: _____ Date: _____

ACCIDENT HISTORY

Date of accident: _____ Time: _____ AM/PM

Driver of car: _____

Where were you seated? _____

Who owns the car? _____

Year & Model of the car you were in during the accident. _____

Year & Model of the other vehicle in the accident. _____

What was the approximate damage done to your car? \$ _____

Visibility at time of accident: poor fair good other: _____

Road conditions at time of accident: icy rainy wet clear dark other (describe): _____

Where was your car struck?

FRONT



REAR

In your own words, please describe the accident: _____

Type of collision: Head-on Broad-side Front Impact Rear-end car in front Rear impact Non-collision

At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____

Did you see the accident coming? NO YES If yes, did you brace for impact? NO YES

Were seatbelts worn? NO YES If yes, were shoulder harnesses worn? NO YES

Did the car you were in have headrests? NO YES

If yes, what was the position of those headrests compared to your head before the accident?

- Top of headrest even with **bottom of head**
- Top of headrest even with **middle of neck**
- Top of headrest even with **top of head**

Was your car braking? NO YES Was your car moving at the time of the accident? NO YES

If yes, how fast would you estimate you were going? _____ mph The other car? _____ mph

Head/Body position at the time of impact:

- Head turned left/right Head looking back Head straight forward
- Body straight in sitting position Body rotated left/right Other: _____

As a result of the accident you were:

- Rendered unconscious In shock Dazed, circumstances vague Other: _____

How was the shoulder harness adjusted? Loose Snug

Were you wearing a hat or glasses? NO YES

Could you move all parts of your body? NO YES

If no, what parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? NO YES

If no, why not? _____

Did you get any bleeding cuts? NO YES If yes, where? _____

Did you get any bruises? NO YES If yes, where? _____

Describe how you felt immediately after the accident: _____

Later that day: _____

The next day: _____

Name: _____ Date: _____

Check symptoms apparent since the accident:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Neck pain/Stiffness | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Anxious/Nervousness | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Breath shortness | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression | <input type="checkbox"/> Ringing/Buzzing | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Clicking/Popping jaw | <input type="checkbox"/> Diarrhea |

Others: _____

Occupation: _____ Employer: _____

Have you missed time from work: NO YES

If yes, full time off work: _____ to _____

If yes, part time off work: _____ to _____

Did you seek medical help immediately after the accident: NO YES

If yes, how did you get there: Ambulance Police Someone drove me Drove myself Other: _____

Doctor #1: Name: _____ First Visit Date: _____

Were you examined? NO YES Were X-rays taken? NO YES

Did you receive treatment? NO YES Medications Braces Collars

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment? _____

Doctor #2: Name: _____ First Visit Date: _____

Were you examined? NO YES Were X-rays taken? NO YES

Did you receive treatment? NO YES Medications Braces Collars

If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last treatment? _____

Do you have an attorney on this claim? NO YES

If yes, who? _____

Address _____

City _____ State _____ Zip _____ Phone _____

Illustrate how the accident happened.

Were there any events you could not attend as a result of the accident? _____

Name: _____

Date: _____

Below are lists of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Pneumonia
- Rheumatic Fever
- Polio
- Tuberculosis
- Whooping Cough
- Anemia
- Measles
- Mumps
- Small Pox
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Thyroid
- Influenza
- Pleurisy
- Arthritis
- Epilepsy
- Mental Disorders
- Lumbago
- Eczema

Have you been tested HIV positive? Yes No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULOSKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/ Stiffness
- Walking Problems
- Difficult Chewing/ Clicking Jaw
- General Stiffness

- Gas/ Bloating After Meals
- Heartburn
- Black/ Bloody Stool
- Colitis

GENITO-URNIARY CODE

- Bladder Trouble
- Painful/ Excessive Urination
- Discolored Urine

NERVOUS SYSTEM CODE

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/ Depression
- Fainting
- Convulsions
- Cold/ Tingling Extremities
- Stress

C-V-R CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/ Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

GENERAL CODE

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

GASTRO-INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/ Infection
- Breast Pain/ Lumps
- Prostate/ Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

FEMALES ONLY:

When was your last period?

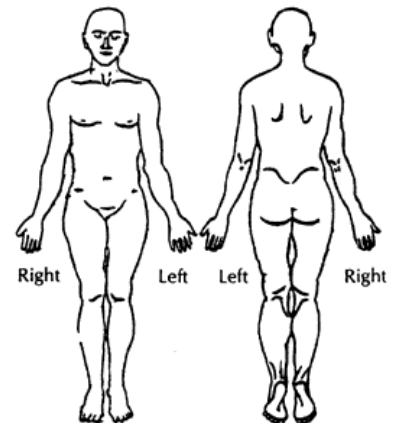
Are you pregnant? Yes No

FAMILY HISTORY

The following members have a same or similar problem as I do:

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

With XXXs please mark the locations of ALL your health problems:



Name: _____

Date: _____

This questionnaire will give Family Chiropractic information about how your BACK condition affects your everyday life.

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the ONE statement that most closely describes your problem. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR BACK.

PAIN INTENSITY

- 0 The pain comes and goes and is very mild.
- 1 The pain is mild and does not vary much.
- 2 The pain comes and goes and is moderate.
- 3 The pain is moderate and does not vary much.
- 4 The pain comes and goes and is very severe.
- 5 The pain is very severe and does not vary much.

SLEEPING

- 0 I get no pain in bed.
- 1 I get pain in bed but it does not prevent me from sleeping well.
- 2 Because of pain my normal sleep is reduced by less than 25%.
- 3 Because of pain my normal sleep is reduced by less than 50%.
- 4 Because of pain my normal sleep is reduced by less than 75%.
- 5 Pain prevents me from sleeping at all.

SITTING

- 0 I can sit in any chair as long as I like.
- 1 I can only sit in my favorite chair as long as I like.
- 2 Pain prevents me from sitting more than 1 hour.
- 3 Pain prevents me from sitting more than ½ hour.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 I avoid sitting because it increases the pain immediately.

STANDING

- 0 I can stand as long as I want without pain.
- 1 I have some pain while standing but it does not increase with time.
- 2 I cannot stand for longer than 1 hour without increasing pain.
- 3 I cannot stand for longer than ½ hour without increasing pain.
- 4 I cannot stand for longer than 10 minutes without increasing pain.
- 5 I avoid standing because it increases pain immediately.

WALKING

- 0 I have no pain while walking.
- 1 I have some pain while walking but it doesn't increase with distance.
- 2 I cannot walk more than 1 mile without increasing pain.
- 3 I cannot walk more than ½ mile without increasing pain.
- 4 I cannot walk more than ¼ mile without increasing pain.
- 5 I cannot walk at all without increasing pain.

PERSONAL CARE

- 0 I do not have to change my way of washing or dressing in order to avoid pain.
- 1 I do not normally change my way of washing or dressing even though it causes some pain.
- 2 Washing and dressing increases the pain but I manage not to change my way of doing it.
- 3 Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- 4 Because of the pain I am unable to do some washing and dressing without help.
- 5 Because of the pain I am unable to do any washing and dressing without help.

LIFTING

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor.
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- 4 Pain prevents me from lifting heavy weights if they are conveniently positioned.
- 5 I can only lift very light weights.

TRAVELING

- 0 I get no pain while traveling.
- 1 I get some pain while traveling but none of my usual forms of travel make it worse.
- 2 I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- 3 I get extra pain while traveling which causes me to seek alternate forms of travel.
- 4 Pain restricts all forms of travel except that done while lying down.
- 5 Pain restricts all forms of travel.

SOCIAL LIFE

- 0 My social life is normal and gives me no extra pain.
- 1 My social life is normal but increases the degree of pain.
- 2 Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc).
- 3 Pain has restricted my social life and I do not go out very often.
- 4 Pain has restricted my social life to my home.
- 5 I have hardly any social life because of the pain.

CHANGING DEGREE OF PAIN

- 0 My pain is rapidly getting better.
- 1 My pain fluctuates but overall is definitely getting better.
- 2 My pain seems to be getting better but improvement is slow.]
- 3 My pain is neither getting better or worse.
- 4 My pain is gradually worsening.
- 5 My pain is rapidly worsening.

Name: _____

Date: _____

This questionnaire will give Family Chiropractic information about how your NECK condition affects your everyday life.

Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the ONE statement that most closely describes your problem. Circle the number that corresponds to your answer.

PLEASE ANSWER THESE QUESTIONS SPECIFIC TO YOUR NECK.

PAIN INTENSITY

- 0 I have no pain at the moment.
- 1 The pain is very mild at the moment.
- 2 The pain comes and goes and is moderate.
- 3 The pain is fairly severe at the moment.
- 4 The pain is very severe at the moment.
- 5 The pain is the worst imaginable at the moment.

SLEEPING

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- 2 My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- 4 My sleep is greatly disturbed (3-5 hours sleepless).
- 5 My sleep is completely disturbed (5-7) hours sleepless).

READING

- 0 I can read as much as I want with no neck pain.
- 1 I can read as much as I want with slight neck pain.
- 2 I can read as much as I want with moderate neck pain.
- 3 I cannot read as much as I want because of moderate neck pain.
- 4 I can hardly read at all because of severe neck pain.
- 5 I cannot read at all because of neck pain.

CONCENTRATION

- 0 I can concentrate fully when I want with no difficulty.
- 1 I can concentrate fully when I want with slight difficulty.
- 2 I have a fair degree of difficulty concentrating when I want.
- 3 I have a lot of difficulty concentrating when I want.
- 4 I have a great deal of difficulty concentrating when I want.
- 5 I cannot concentrate at all.

WORK

- 0 I can do as much work as I want.
- 1 I can only do my usual work but no more.
- 2 I can only do most of my usual work but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do any work at all.
- 5 I cannot do any work at all.

PERSONAL CARE

- 0 I can look after myself normally without causing extra pain.
- 1 I can look after myself normally but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help but I manage most of my personal care.
- 4 I need help every day in most aspects of self care.
- 5 I do not get dressed, I wash with difficulty and stay in bed.

LIFTING

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights but it causes extra pain.
- 2 Pain prevent me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- 4 I can only lift very light weights.
- 5 I cannot lift or carry anything at all.

DRIVING

- 0 I can drive my car without any neck pain.
- 1 I can drive my car as long as I want with slight neck pain.
- 2 I can drive my car as long as I want with moderate neck pain.
- 3 I cannot drive my car as long as I want because of moderate neck pain.
- 4 I can hardly drive at all because of severe neck pain.
- 5 I cannot drive my car at all because of neck pain.

RECREATION

- 0 I am able to engage in all my recreation activities without neck pain.
- 1 I am able to engage in all my usual recreation activities with some neck pain.
- 2 I am able to engage in most but not all my usual recreation activities because of neck pain.
- 3 I am only able to engage in a few of my usual recreation activities because of neck pain.
- 4 I can hardly do any recreation activities because of neck pain.
- 5 I cannot do any recreation activities at all.

HEADACHES

- 0 I have no headaches at all.
- 1 I have slight headaches which come infrequently.
- 2 I have moderate headaches which come infrequently.
- 3 I have moderate headaches which come frequently.
- 4 I have severe headaches which come frequently.
- 5 I have headaches almost all the time.