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**APPLICATION FOR CARE AT Total Health Chiropractic, PSC**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_Primary Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your problem the result of ANY type of accident, Personal Injury Case or Workers Compensation Incident?** 🞏 Yes, 🞏 No Identify any other injury(s) to your spine, minor or major, that the doctor should know about:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **❑** Single **❑** Married **❑** Widowed **❑** Divorced Do you have Insurance: **❑** Yes **❑** No

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name/Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor (legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Fifth: Circle if you suffer pain with any of these: Wrist Elbow Shoulders TMJ(Jaw Pain) Ankle/Feet Knee Hip**

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** complaints 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

**Fifth** 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 makes symptoms feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE: WEIGHT: L\_\_\_\_\_ R\_\_\_\_\_ TOTAL\_\_\_\_\_ BP/HR: \_\_\_\_\_\_\_\_\_ Estim: Y/N X-ray: C/S T/S L/S Therapeutic Exercise : Y/N**

Please identify 3 or 4 key values that your current condition is affecting your ability to carry out that are routinely part of your life:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** |  |  |  |  |
|  | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
|  | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
|  | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
|  | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |

**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 whoprovided 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark P** for **Past** condition**, C** for **Current** condition

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ High Cholesterol

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ Asthma

\_\_\_ Low Back Pain \_\_\_ Foot or Knee Problems \_\_\_ Hearing Loss \_\_\_ Menstrual Problem \_\_\_ Difficulty Breathing

\_\_\_ Hip Pain \_\_\_ Sinus/Drainage Problem \_\_\_ Depression \_\_\_ PMS \_\_\_ Lung Problems

\_\_\_ Back Curvature \_\_\_ Swollen/Painful Joints \_\_\_ Irritable \_\_\_ Bed Wetting \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

***\_\_\_ Broken Bone \_\_\_Dislocations \_\_\_ Tumors \_\_\_Rheumatoid Arthritis \_\_\_ Fracture***

***\_\_\_Disability \_\_\_Cancer \_\_\_ Heart Attack \_\_\_Osteo Arthritis \_\_\_ Diabetes***

***\_\_\_Cerebral Vascular \_\_\_Other serious conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**PLEASE identify** **ALL PAST** and any **CURRENT** conditions:

|  |
| --- |
| **HOW LONG AGO TYPE OF CARE RECEIVED BY WHOM** |
| **INJURIES 🡪** |
| **SURGERIES 🡪** |
| **CHILDHOOD DISEASES🡪** |
| **ADULT DISEASES 🡪** |

**List Prescription & Non-Prescription drugs you take**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**1. Smoking/Tobacco**: ❑cigars ❑pipe ❑cigarettes ❑Chew/Dip 🡪 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Whom may we thank for referring you to this office 🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?***

I hereby authorize payment to be made directly to Total Health Chiropractic, PSC 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 Total Health Chiropractic, PSC for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient or Authorized Person’s Signature Date Completed**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

**Doctor’s Signature Date Form Reviewed**

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CURRENT: GOAL: