TOTAL HEALTH CHIROPRACTIC

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

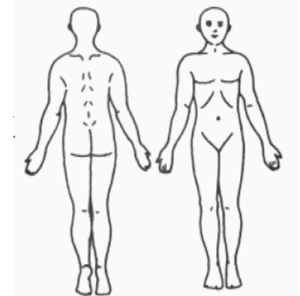
When did the problem(s) begin? ____________________ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM
How long does it last? □ It is constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week

How did the injury happen?_____________

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 = 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 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:

____

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**

QUADRUPLE VISUAL ANALOGUE SCALE

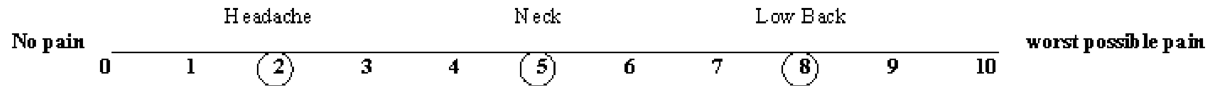
Patient Name ________________________________ Date ____________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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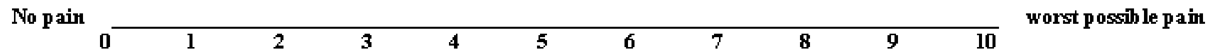
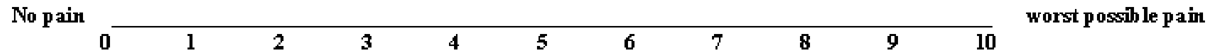
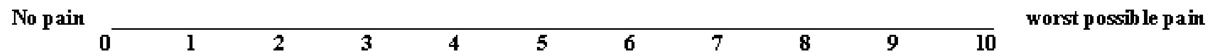
1 – What is your pain RIGHT NOW?



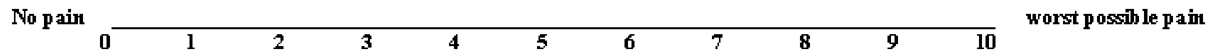
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

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Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

CURRENT: GOAL: