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

_______________ _______________ _______________ _M_F_ _______________
DATE OF BIRTH AGE SOCIAL SECURITY # (FOR INSURANCE) SEX MARITAL STATUS

____
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.	Describe your health problem. (10 is the most severe) ***Circle** the number for severe.* ***Put an X** on the average pain.*	What percentage of your waking day do you feel your health problems? (100% is constant)
HEAD PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 1. Headaches or Migraines	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 2. TMJ (jaw) Pain/Clicking	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
SPINAL PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 3. Neck □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 4. Upper Shoulder (trapezius) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 5. Upper Back (Shoulder blades) Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 6. Middle Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 7. Low Back □ Pain □ Stiffness	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 8. Pelvis/Buttock Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
UPPER EXTREMITY (ARM) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 9. Shoulder Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 10. Elbow Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 11. Wrist Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 12. Hand □Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 13. Arm □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
LOWER EXTREMITY (LEG) PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 14. Hip Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 15. Knee Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 16. Ankle Joint Pain	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 17. Foot □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 18. Leg □ Pain □Numbness □Tingling	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
CHEST, ABDOMINAL OR PELVIC PROBLEMS	WHICH SIDE?	MILD MODERATE SEVERE	OCCASIONAL CONSTANT
□ 19. Chest Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 20. Abdominal Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	0% 25% 50% 75% 100%
□ 21. Pelvic Pain/ Symptoms	□ Left □ Both □ Right	0 1 2 3 4 5 6 7 8 9 10	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?

□ Bending over	□ Driving Car	□ Household chores	□ Reaching overhead	□ Staying asleep
□ Caring for family	□ Exercising	□ Lifting objects	□ Rising out of chair / bed	□ Using a computer
□ Climbing stairs	□ Getting in/out of car	□ Looking over shoulder	□ Showering or bathing	□ Walking
□ Concentrating	□ Getting to sleep	□ Making love	□ Sitting	□ Participating in yardwork
□ Dressing self	□ Grocery shopping	□ Lying down	□ Standing	

Other activities not listed: ____

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

NERVOUS SYSTEM CODE

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

GENERAL CODE

□ Fatigue
□ Allergies
□ Loss of Sleep
□ Fever
□ Headaches

GASTRO-INTESTINAL CODE

□ Poor/Excessive Appetite
□ Excessive Thirst
□ Frequent Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Hemorrhoids
□ Liver Problems
□ Gall Bladder Problems
□ Weight Trouble
□ Abdominal Cramps
□ Gas/ Bloating After Meals
□ Heartburn
□ Black/ Bloody Stool
□ Colitis

GENITO-URNIARY CODE

□ Bladder Trouble
□ Painful/ Excessive Urination
□ Discolored Urine

C-V-R CODE

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

EENT CODE

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

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?
____

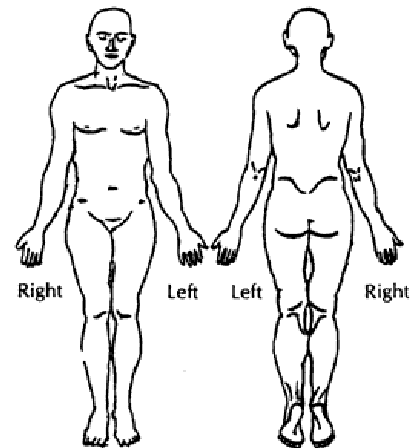
Are you pregnant? Yes No

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:



Patient Signature: ____Date: ____________________

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.

PERSONAL CARE

0 I would 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, but I can if they are in convenient places (e.g. on a table).
3 Pain prevents me from lifting heavy weights off the floor.
4 Pain prevents me from lifting heavy weights, but I can manage medium weights if they are conveniently positioned.
5 I can only lift very light weights at the most.

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.

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 my pain right away.

STANDING

0 I can stand as long as I want without extra 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 the pain right away.

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.

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 as often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of pain.

TRAVELING

0 I get no pain while traveling.
1 I get some pain while traveling, but none of my usual forms of travel makes it any worse.
2 I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3 I get extra pain while traveling, which compels me to seek alternate forms of travel.
4 Pain restricts all forms of travel.
5 Pain restricts all forms of travel except that done while lying down.

CHANGING DEGREE OF PAIN

0 My pain is rapidly getting better.
1 My pain fluctuates, but is definitely getting better.
2 My pain seems to be getting better but improvement is slow at present.
3 My pain is neither getting better nor 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 <u>NECK</u>.

PAIN INTENSITY

0 I have no pain at the moment.
1 The pain is very mild at the moment.
2 The pain is moderate at the moment.
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.

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 prevents 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, but I can manage medium weights if they are conveniently positioned.
4 I can lift very light weights.
5 I cannot lift or carry anything at all.

READING

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

HEADACHES

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

CONCENTRATION

0 I can concentrate fully when I want with no difficulty.
1 I can concentrate fully when I want to 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 to.
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 can't do any work 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 pain in my neck.
2 I can drive my car as long as I want with moderate pain in my neck.
3 I can't drive my car as long as I want because of moderate pain in my neck.
4 I can hardly drive at all because of severe pain in my neck.
5 I can't drive my car at all.

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 (3-4 hours sleepless).
5 My sleep is completely disturbed (5-7 hours sleepless).

RECREATION

0 I am able to engage in all my recreation activities with no neck pain at all.
1 I am able to engage in all my usual recreation activities with some pain in my neck.
2 I am able to engage in most, but not all my usual recreation activities because pain in my neck.
3 I am only able to engage in a few of my usual recreation activities because of pain in my neck.
4 I can hardly do any recreation activities because of pain in my neck.
5 I can't do any recreation activities at all.