

Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT SUMMIT CHIROPRACTIC

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married 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: Primarily: _____

Secondarily: _____ 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: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth 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

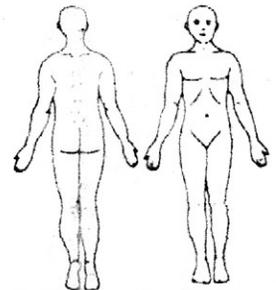
How did the injury happen? _____

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 = 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 and **N** for **Never have had**:

- ___ 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 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

- Smoking: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never
- Alcoholic Beverage: consumption occurs → Daily Weekends Occasionally Never
- Recreational Drug use: Daily Weekends Occasionally Never
- Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

FAMILY HISTORY:

- 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
- Any other hereditary conditions the doctor should be aware of. No Yes: _____

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

Patient or Authorized Person's Signature

Date Completed

Doctor's Signature

Date Form Reviewed

Patient's Name: _____ HR#: _____ / / _____ JDD,DC 5/2011

SUMMIT CHIROPRACTIC

Patient's Name: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting you ability to carry out activities that are routinely part of life:

Activities: _____ EFFECT: _____

| | |
|-----------------------|---|
| Carrying Groceries | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Sit to stand | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Climbing Stairs | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Pet Care | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Driving | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Extended Computer Use | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Lifting Children | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Reading/Concentration | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Bathing | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Dressing | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Shaving | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Sexual Activities | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Static Sitting | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Static standing | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Yard Work | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Sweeping/Vacuuming | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Dishes | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Laundry | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |
| Other: _____ | <input type="checkbox"/> No Effect <input type="checkbox"/> Painful (can do) <input type="checkbox"/> Painful (limits) <input type="checkbox"/> Unable to Perform |

Patient Signature: _____ Today's Date: _____

Patient signature: _____ Today's Date: ___/___/___

Please mark P for in the Past, C for Currently have and N for Never

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

List Prescription & Non-Prescription drugs you take: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

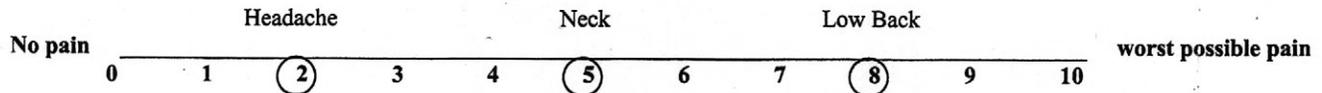
Date _____

Please read carefully:

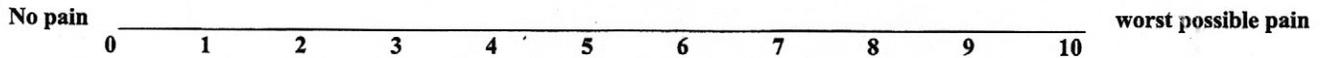
Instructions: Please circle the number that best describes the question being asked.

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.

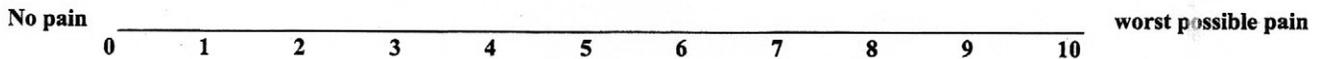
Example:



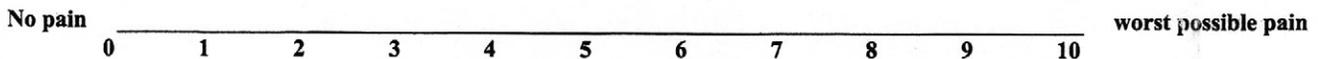
1 – What is your pain RIGHT NOW?



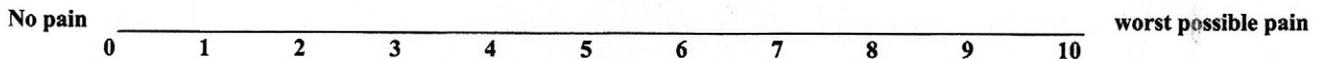
2 – What is your TYPICAL or AVERAGE pain?



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:

Examiner _____

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