APPLICATION FOR CHIROPRACTIC CARE & CONFIDENTIAL CASE HISTORY

Dear Patient: Please complete this questionnaire. Your answers will help us determine if Chiropractic can help you.
If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **PLEASE PRINT, THANK YOU.**

NAME ____________________ BIRTHDATE ____________ AGE ______

ADDRESS ____________________ TEL __________ WORK __________

CITY ____________ ZIP ______ SS# __________ SPOUSE SS# __________

OCCUPATION ____________________ EMPLOYER ____________________

SPOUSE ____________ # OF CHILDREN ____ DRIVER LIC# ________ REFER BY ________

SPOUSE'S OCCUPATION ____________________ EMPLOYER ____________________

NAME OF INSURANCE COMPANY ____________________ PH# __________

ADDRESS ____________________ CITY __________ STATE ______ ZIP ______

POLICY NO. ____________________ NAME OF INSURED ____________________

TYPE OF COVERAGE: ❑ GROUP ❑ PERSONAL ❑ ACCIDENT ❑ INDUSTRIAL ❑ MEDICARE

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS: ____

____

LOCATION OF PAIN: ____

IS THIS A RESULT OF AN SPECIFIC INCIDENT? (EXPLAIN) ____

WHEN DID IT START? ____

WHAT ACTIVITIES MAKE IT WORSE? ____

IS THIS CONDITION GETTING WORSE? ❑ YES ❑ NO ❑ CONSTANT ❑ COMES AND GOES

DOES THIS CONDITION INTERFERE WITH: ❑ WORK ❑ SLEEP ❑ DAILY ACTIVITY ❑ OTHER __________

IS THIS CONDITION DUE TO: ❑ PERSONAL INJURY ❑ ON-THE-JOB INJURY ❑ AUTO ACCIDENT

HAVE YOU DONE ANYTHING TO TREAT THIS CONDITION YOURSELF? ____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO THEIR NAMES __________

DR'S DIAGNOSIS ____

RESULTS: ❑ GOOD ❑ FAIR ❑ POOR ❑ NONE

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. **THIS IS A CONFIDENTIAL HEALTH REPORT.**

- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ NECK GRATING
- ❑ NECK TENSION
- ❑ MID-BACK PAIN
- ❑ MID-BACK STIFFNESS
- ❑ MID-BACK GRATING
- ❑ MID-BACK TENSION
- ❑ LOW-BACK PAIN
- ❑ LOW-BACK STIFFNESS
- ❑ LOW-BACK GRATING
- ❑ LOW-BACK TENSION

PAIN IN:

- ❑ SHOULDERS
- ❑ ARMS
- ❑ HANDS
- ❑ HIPS
- ❑ LEGS
- ❑ FEET

NUMBNESS IN:

- ❑ SHOULDERS
- ❑ ARMS
- ❑ HANDS
- ❑ HIPS
- ❑ LEGS
- ❑ FEET
- ❑ PAINFUL TAIL BONE
- ❑ SCIATICA
- ❑ PAINFUL JOINTS
- ❑ SWOLLEN JOINTS
- ❑ BURSITIS

- ❑ HERNIA
- ❑ PINCHED NERVES
- ❑ HEADACHES
- ❑ MIGRAINES
- ❑ DIZZINESS
- ❑ FAINTING
- ❑ FATIGUE
- ❑ NERVOUSNESS
- ❑ DEPRESSION
- ❑ CONVULSIONS
- ❑ BAD MOODS & BEHAVIOR
- ❑ TREMORS
- ❑ INSOMNIA
- ❑ SWEATS
- ❑ CHILLS
- ❑ BELCHING/GAS
- ❑ COLON TROUBLE
- ❑ CONSTIPATION
- ❑ DIARRHEA
- ❑ INDIGESTION
- ❑ HEMORRHOIDS
- ❑ NAUSEA
- ❑ GALL BLADDER TROUBLE
- ❑ LIVER TROUBLE
- ❑ VOMITING
- ❑ STOMACHACHES
- ❑ ASTHMA
- ❑ ALLERGIES
- ❑ SINUS
- ❑ TONSILLITIS
- ❑ HAY FEVER
- ❑ SORE THROATS
- ❑ EYE PAIN

- ❑ FAILING VISION
- ❑ EAR TROUBLES
- ❑ RINGING IN THE EARS
- ❑ NOSE BLEEDS
- ❑ HIGH BLOOD PRESSURE
- ❑ LOW BLOOD PRESSURE
- ❑ CHEST PAINS
- ❑ POOR CIRCULATION
- ❑ CHRONIC COUGH
- ❑ DIFFICULT BREATHING
- ❑ SKIN ERUPTIONS
- ❑ VARICOSE VEINS
- ❑ ACNE
- ❑ BOILS
- ❑ ITCHING
- ❑ BED WETTING
- ❑ BLOOD IN URINE
- ❑ FREQUENT URINATION
- ❑ PAINFUL URINATION
- ❑ KIDNEY TROUBLE
- ❑ PROSTATE TROUBLE
- ❑ MENSTRUAL CRAMPS
- ❑ EXCESSIVE FLOW
- ❑ IRREGULAR CYCLE
- ❑ **ARE YOU PREGNANT**
- ❑ **MENOPAUSAL SYMPTOMS**
- ❑ LUMPS IN BREAST

CONDITIONS:

- ❑ COLDS
- ❑ FLU
- ❑ ALCOHOLISM
- ❑ ANEMIA

- ❑ ARTERIOSCLEROSIS
- ❑ ARTHRITIS
- ❑ CANCER
- ❑ CROUP
- ❑ DIABETES
- ❑ EPILEPSY
- ❑ HEART DISEASE
- ❑ MISCARRIAGE
- ❑ MULTIPLE SCLEROSIS
- ❑ PNEUMONIA
- ❑ POLIO
- ❑ STROKE
- ❑ T.B.
- ❑ ULCERS
- ❑ MENTAL DISORDERS

OTHER: __________

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____

OTHER COMPLAINTS FOR COMMENTS ____
____
____
____
____

HAVE YOU EVER BEEN IN AN **AUTO ACCIDENT** OR OTHER **SERIOUS INJURIES** INCLUDING **FRACTURES** ❑ YES ❑ NO
IF YES, PLEASE DESCRIBE (GIVE DATES AND / OR AGES) ____
____
____
____

HAVE YOU EVER HAD **SURGERY?** ❑ YES ❑ NO ______________________ IF YES, PLEASE DESCRIBE (GIVE DATES AND / OR AGES)
____
____
____

ARE YOU NOW TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION **DRUGS OR MEDICATION?** ❑ YES ❑ NO
IF YES, PLEASE DESCRIBE (GIVE DATES AND / OR AGES) ____
____
____

HAVE YOU EVER BEEN **HOSPITALIZED?** ❑ YES ❑ NO IF YES, PLEASE DESCRIBE (GIVE DATES AND / OR AGES) ________________
____
____
____

HAVE YOU EVER BEEN TREATED FOR ANY OTHER HEALTH CONDITION IN THE PAST YEAR? ❑ YES ❑ NO IF YES,
PLEASE DESCRIBE (GIVE DATES AND / OR AGES) ____
____
____

HAVE YOU BEEN UNDER CHIROPRACTIC CARE BEFORE? ❑ YES ❑ NO NAME OF DOCTOR ______________________
DATE OF LAST ADJUSTMENT ______________________ RESULTS ____
____

PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE.

- ❑ I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE FEELS IS BEST FOR ME
- ❑ MAXIMUM IMPROVEMENT
- ❑ TEMPORARY RELIEF

EMAIL ____

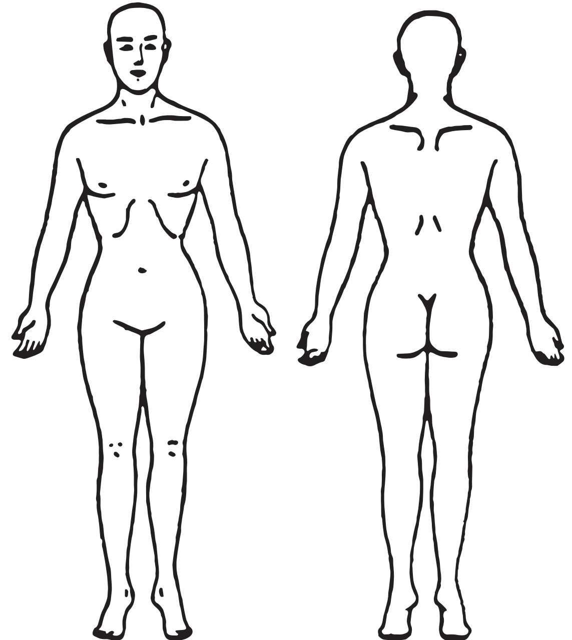
PLEASE SIGN HERE:

I DO HEREBY CERTIFY, THAT ALL OF MY STATEMENTS ON THIS APPLICATION FOR CHIROPRACTIC CARE ARE TRUE, ACCURATE AND COMPLETE.

____
SIGNATURE

DATE ______________________

PLEASE MARK THE AREAS OF PAIN OR INJURY



1 2 3 4 5 6 7 8 9 10

PAIN SCALE: (PLEASE CIRCLE ONE)
TEN BEING THE WORST PAIN EVER EXPERIENCED