**APPLICATION FOR CARE**

**MACEO POWELL, DC, CPE**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HRN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

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

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

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Permission to email appt reminder* **Y** or **N** |Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Permission to text appointment reminder*: **Y** or **N** | My Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Ex: AT&T, Verizon, T-mobile*

Marital Status: Single Married Do you have insurance: Yes No Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s Licence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

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

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** complaint 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

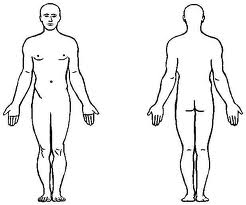
When did the problem(s) begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? AM PM Mid-day late PM

How long does it last? Is it constant OR I experience it on and off during the day OR It comes and goes throughtout 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** = **R**adiation **B**= **B**urning **D**=**D**ull **A**=**A**ching **N**=**N**umbness **S**=**S**harp/**S**tabbing **T**=**T**ingling

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 indicaet with a **P** for in the ***Past***, **C** for ***Currently***

and **N** for ***Never*** *had it*:

\_\_\_\_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 problems:

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

**SOCIAL HISTORY**

1. Smoking: cigars pipe cigarettes How often? Daily Weekends Occasionally Never

1. Alcoholic Beverages: consumption occurs? Daily Weekends Occasionally Never

1. Recreational Drug use: Daily Weekends Occasionally Never

1. Hobbies-Recreational Activities-Exercise Regime: How does your present problem affect the following, See pg. 2 Activities of Daily Living

**FAMILY HISTORY**

1. Does anyone in your family suffer with the same condition(s)? No Yes

If yes whom: grandmother mother father sister’s brother’s son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don’t know

I hereby authorize payment to be made directly to Powell Family 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 acknowledgement that this assignment of benefits does not in any way relieve me of payment liability and that will remain financially responsible Powell Family 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#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_\_/\_\_\_\_**

**Activities of Daily Living/Symptoms/Medications**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ File#\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daily Activities: Effects of Current conditions On Performance**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bending | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Concentrating | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Doing computer Work | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Gardening | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Playing Sports | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Recreation Activities | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Shoveling | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sleeping | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Watching TV | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Carrying | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Dancing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Dressing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Lifting | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Pushing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Rolling Over | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sitting | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Standing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Working | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Climbing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Doing Chores | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Driving | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Performing Sexual Activity | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Reading | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Running | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Sitting to Standing | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |
| Walking | No Effect | Painful (can do) | Painful (Limits) | Unable to Perform |

**Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ 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 \_\_\_ Low Blood Pressure

\_\_\_ 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)

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

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

