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 _____ PHONE _____ (WORK) _____

OCCUPATION _____ EMPLOYER _____

SPOUSE _____ # OF CHILDREN _____ REFERRED BY _____

SPOUSES OCCUPATION _____ EMPLOYER _____

NAME OF INSURANCE COMPANY _____ PH.# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICY NO. _____ NAME OF AGENT _____

TYPE OF COVERAGE ❑ GROUP ❑ PERSONAL ❑ ACCIDENT ❑ INDUSTRIAL ❑ MEDICARE ❑ MEDICAL ASSISTANCE

SOCIAL SECURITY NUMBER _____ MARITAL STATUS S M D W

PLEASE DESCRIBE YOUR MAJOR COMPLAINTS: _____

_____

_____

_____

LOCATION OF PAIN? _____

IS THIS THE RESULT OF A SPECIFIC INCIDENT (EXPLAIN) _____

WHEN DID IT START? _____ HAVE YOU EVER HAD THIS CONDITION BEFORE? ❑ YES ❑ NO

IF YES, PLEASE DESCRIBE: _____

WHAT ACTIVITIES MAKE IT WORSE? _____

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

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

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

HAVE YOU DONE ANYTHING TO TREAT THIS CONDITION YOURSELF? _____

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

HIS DIAGNOSIS _____

RESULTS: ❑ GOOD ❑ FAIR ❑ POOR ❑ NONE

Please Place a check (✓) in the appropriate box of any symptoms you are currently having and place an (x) in the box of an symptoms you 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
❑ STOMACH ACHES
❑ 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 _____
_____
_____
_____
_____

OTHER COMPLAINTS OR COMMENTS: _____

HAVE YOU EVER BEEN IN AN **AUTO ACCIDENT** OR OTHER SERIOUS **INJURIES** ❑ YES ❑ NO. I F 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 GIVE NAMES AND FOR WHAT CONDITION: _____

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

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITION IN THE PAST YEAR? ❑ YES ❑ NO. IF YES, PLEASE DESCRIBE:

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

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

YOUR SIGNATURE _____ DATE _____