

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

### APPLICATION FOR CARE AT TRUE HEALTH CHIROPRACTIC

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

#### PATIENT DEMOGRAPHICS

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

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

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Name of Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Names and Ages of your children: \_\_\_\_\_

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 a: 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

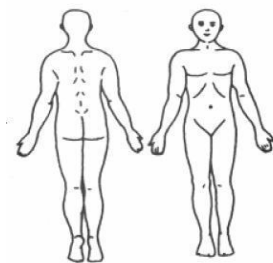
How did the injury happen? \_\_\_\_\_ Condition(s) ever been treated by anyone in the past?  No  Yes

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 \_\_\_ OsteoArthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions:

**PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing 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 TRUE HEALTH 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 TRUE HEALTH 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

**General Health and Wellness Questionnaire:**

When was your most recent auto accident, work related injury or spinal trauma? Please describe necessary details.

- \_\_\_\_\_  
 Have you tested with high triglycerides or high cholesterol? (Y/N) \_\_\_\_\_  
 Values? Have you tested with high blood pressure? (Y/N) \_\_\_\_\_  
 Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y/N) \_\_\_\_\_  
 Do you regularly drink (1 or more per day) any of the following? (circle all that apply) Diet Soda Coffee Juice Milk  
 Soda Alcohol  
 How many times per week do you exercise? \_\_\_\_\_  
 What is your target weight? \_\_\_\_\_ What is your current weight? \_\_\_\_\_  
 Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y/N) \_\_\_\_\_  
 Do you ever take pill to sleep or relax? (Y/N) \_\_\_\_\_

## Activities of Daily Living/Symptoms/Medications

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your 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
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<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
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Groceries	<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

**Please mark P for in the Past, C for Currently have and 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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_