

T 1 2 3

Date ___/___/___

New Practice Member Application

Name _____ Date of Birth ___/___/___ Age ___ Male/Female

Address _____ City _____ State ___ Zip _____

Phone: Cell _____ Home _____ Cellular Provider _____

Email Address _____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children ___ Names, Ages, & Gender _____

Who may we thank for referring you? _____



List the Health Concerns That Brought You into This Office



| Health Concern: List according to severity | Rate of Severity 0 = no pain 10 = unbearable | When did this problem start? | Have you had the problem before? If so, when? | Did the problem begin with an injury? | Are symptoms constant (C) or intermittent (I)? |
|-----------------------------------------------|----------------------------------------------------|------------------------------------|-----------------------------------------------------|---------------------------------------------|------------------------------------------------------|
| Primary: _____ | _____ | _____ | _____ | _____ | _____ |
| Second: _____ | _____ | _____ | _____ | _____ | _____ |
| Third: _____ | _____ | _____ | _____ | _____ | _____ |
| Fourth: _____ | _____ | _____ | _____ | _____ | _____ |

Have you ever seen other doctors for these conditions? Yes No

If Yes: Chiropractor Medical doctor Other _____

Who and when? _____

What were the results? Favorable Unfavorable (please explain) _____

Please Mark "P" For In The Past, OR Mark "C" For Currently Have:

- Headaches Ear Infections Sinus Issues Kidney Problems Sexual Dysfunction
- Migraines Hearing Loss Frequent Colds Bladder Problems Sleep Problems
- Jaw/TMJ Pain Ringing in the Ears Thyroid Issues Menstrual Problems Tight/Sore Muscles
- Neck Pain Dizziness Asthma Prostate Problems Sports Injury
- Shoulder Pain Loss of Energy Chest Pain Infertility Sciatica
- Arm Pain Nervousness Heart Problems Fibromyalgia Arthritis/Joint Pain
- Upper Back Pain Double/Blurry Vision Nausea Epilepsy/Convulsions GERD/Gastric Reflux
- Mid Back Pain Anxiety Ulcers Tremors Numb/Tingling in Arms/Hands
- Lower Back Pain ADD/ADHD Digestive Issues Disc Problems Numb/Tingling in Legs/Feet
- Hip/Leg Pain Loss of Balance Diarrhea Scoliosis Stomach Problems
- Knee Pain Depression Constipation Poor Posture High/Low Blood Pressure
- Foot Pain Allergies Bed Wetting Skin Problems Difficulty Breathing

Other: _____

Please Mark "P" For In The Past, OR Mark "C" For Currently Have:

- Stroke Cancer Heart Attack Spinal Surgery Spinal Bone Fracture
- Scoliosis Diabetes Arthritis Seizures Other Conditions/Diseases

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about: _____

List all over the counter & prescription medications you are on, & the reason for each: _____

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? Yes No Fractured A Bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____

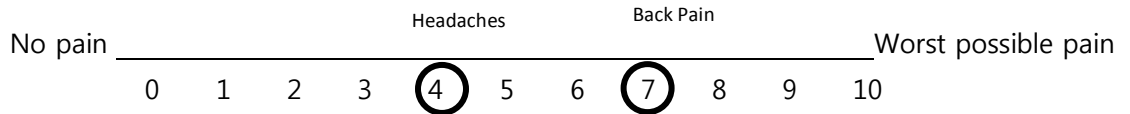
Social History

1. Smoking: How often? Daily Weekends Occasionally Never
2. Alcohol: How often? Daily Weekends Occasionally Never
3. Exercise: How often? Daily Weekends Occasionally Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours? Yes No

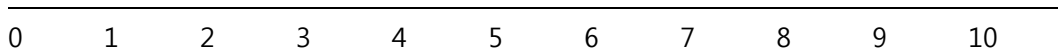
Quadruple Visual Analogue Scale

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

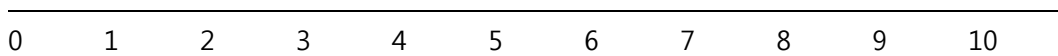
EXAMPLE:



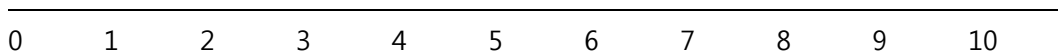
1. How would you rate your pain **RIGHT NOW**?



2. What is your typical or **AVERAGE** pain?

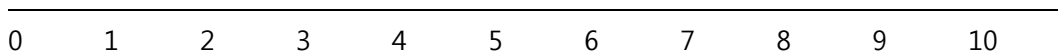


3. What is your pain level at its **BEST**? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its **WORST**? (How close to 10 does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1_____+Q2_____+Q4_____ = _____ /3x10= _____ (Low Intensity = <50; High Intensity = >50)

Activities Of Life

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

ACTIVITY:

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 |
| 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 |
| 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/Vacuuuming | <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 |
| Yard work | <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 |
| Concentration (Reading) | <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 |
| Other: _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

Family Health History

This form is to assist the doctors by providing past health history information for their review.

| CONDITION | SPOUSE | SON | DAUGHTER | MOTHER | FATHER |
|-------------------------|--------|-----|----------|--------|--------|
| Headaches | | | | | |
| Neck Pain | | | | | |
| Jaw/TMJ Pain | | | | | |
| Shoulder Pain | | | | | |
| Back Pain | | | | | |
| Hip/Leg Pain | | | | | |
| Arthritis/Joint Pain | | | | | |
| Ear Infections | | | | | |
| Dizziness | | | | | |
| Loss Of Energy | | | | | |
| Nervousness | | | | | |
| Blurred/Double Vision | | | | | |
| Anxiety | | | | | |
| ADD/ADHD | | | | | |
| Depression | | | | | |
| Allergies | | | | | |
| Sinus Issues | | | | | |
| Thyroid Problems | | | | | |
| Asthma | | | | | |
| Breathing Problems | | | | | |
| Heart Problems | | | | | |
| High/Low Blood Pressure | | | | | |
| Stomach Problems | | | | | |
| Bed Wetting | | | | | |
| Infertility | | | | | |
| Sciatica | | | | | |
| Fibromyalgia | | | | | |
| Poor Posture | | | | | |
| Sleep Problems | | | | | |
| Stroke | | | | | |
| Cancer | | | | | |
| Diabetes | | | | | |
| Arthritis | | | | | |