Today's Date_____/_____/_____

Shifting Tides
CHIROPRACTIC

New Practice Member Adult Application

Name _____ Date of Birth _____/_____/_____ Age____ Male/Female

Address _____ City_____ State_____ Zip_____

Cell Phone _____ Cellular Provider (for appointment reminders)_____

Home Phone _____ Email Address _____

Occupation _____ Employer's Name_____

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

Children's Names, Ages, & Gender_____

Who may we thank for referring you? _____

Emergency Contact Name:_____ Phone:_____

Address_____

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 problems begin with an injury?	Are symptoms Constant or Intermittent?
Primary: _____	_____	_____	_____	Yes/No	Constant/Intermittent
Second: _____	_____	_____	_____	Yes/No	Constant/Intermittent
Third: _____	_____	_____	_____	Yes/No	Constant/Intermittent
Fourth: _____	_____	_____	_____	Yes/No	Constant/Intermittent

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) _____

Were X-rays/ MRI / or CT Scan taken within the last 2 years Yes/NO If yes when, and what area? _____

_____

Providers/Facility name and address_____

Please Mark “C” for Currently Have or “P” for Had in the Past

___Headaches
___Migraines
___Rt/Lt Jaw/TMJ pain
___Neck Pain
___Rt/Lt Shoulder Pain
___Rt/Lt Arm Pain
___Rt/Lt Numb/ Tingling in Arms/Hands
___Upper Back Pain
___Mid Back Pain
___Low Back Pain
___Disc Problems
___Scoliosis
___Sciatica
___Rt/Lt Knee Pain
___Rt/Lt Foot Pain
___Rt/Lt Numb/ Tingling Legs/Feet
___Arthritis/Joint Pain

___Tight Sore Muscles
___Fibromyalgia
___Sports Injury
___Rt/Lt Double/Blurry Vision
___Dizziness
___Ear Infections
___Rt/Lt Hearing Loss
___Rt/Lt Ringing in the Ears
___Sinus Infections
___Allergies
___Thyroid Issues
___Frequent Colds
___Asthma
___Difficulty Breathing
___Chest Pain
___Heart Problems
___High/Low Blood Pressure

___Stomach Problems
___GERD/Gastric Reflux
___Nausea
___Digestion Problems
___Ulcers
___Diarrhea
___Constipation
___Kidney Problems
___Bladder Problems
___Day/Night Incontinence
___Menstrual Problems
___Prostate Problems
___Infertility
___Sexual Dysfunction
___Energy Loss
___Nervousness
___Anxiety

___Depression
___Sleep Problems
___Poor Posture
___Skin Problems
___Loss of Balance
___ADD/ADHD
___Tremors
___Epilepsy/Convulsions
___Autism
___Stress
___Seizures
___Stroke
___Diabetes
___Cancer
___Heart Attack
___Spinal Bone Fracture

Other Conditions/Diseases or injuries to your spine (major or minor) that the doctor should know about. N/A for none:

_____

List all Prescription, Over the Counter medications, Vitamins & Supplements you are on AND the reason for each. N/A for none:

_____

_____

_____

Have you ever been knocked unconscious? Yes/No Fractured a bone? Yes/No

If yes to either please explain:_____

Other Trauma (ex. car accident) _____

Social History

1. Caffeine: How often? Within the last 48 hours / Daily / Weekends / Occasionally / Quit / Never
2. Alcohol: How often? Daily / Weekends / Occasionally / Quit / Never
3. Tobacco/Vaping : How often? Daily / Weekends / Occasionally / Quit / Never
4. Exercise: How often? Daily / Occasionally /Never

Quadruple Visual Analogue Scale

Focus on 1 body part at a time that is in pain. Please circle the number that best describes the question asked.

BODY AREA IN PAIN: ______________________

1. **RIGHT NOW**, how would you rate your pain?

____

0 1 2 3 4 5 6 7 8 9 10

2. **ON AVERAGE** what is your typical pain?

____

0 1 2 3 4 5 6 7 8 9 10

3. **AT IT'S BEST**, how close does your pain get to zero (0)?

____

0 1 2 3 4 5 6 7 8 9 10

4. **AT IT'S WORST**, how close does your pain get to ten (10)?

____

0 1 2 3 4 5 6 7 8 9 10

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0 1 2 3 4 5 6 7 8 9 10

___________________________________DO NOT WRITE BELOW THIS LINE_____________________________

Area__________________ Q1_______ + Q2_______+ Q4_______=_______ /3x 10 _________

Area__________________ Q1_______ + Q2_______+ Q4_______=_______ /3x 10 _________

Area__________________ Q1_______ + Q2_______+ Q4_______=_______ /3x 10 _________

Area__________________ Q1_______ + Q2_______+ Q4_______=_______ /3x 10 _________

Activities of Life

Please mark how your current condition is affecting your ability to do activities that are routinely part of your life:

Activity:	Effect:			
Washing/Bathing	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Shaving	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Dressing	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Stand up from Sitting	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Climbing Stairs	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Walking	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Sitting for a period of time	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Standing for a period of time	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Sleeping	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Driving	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Extended Computer Use	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Concentration (Reading)	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Carrying Groceries	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Lifting Objects	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Picking up Children	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Sweeping/Vacuuming	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Laundry	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Dishes	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Yard Work	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Pet Care	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Other:_____	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do
Other:_____	○ No Effect	○ Can do but painful	○ Painful I do with limits	○ Too much pain to do

Family Health History

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

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