



Today's Date ____/____/____

New Practice Member Application Age 8 - 17

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 _____

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tight Sore Muscles | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> GERD/Gastric Reflux | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Rt/Lt Jaw/TMJ pain | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Rt/Lt Double/Blurry Vision | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Rt/Lt Shoulder Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Rt/Lt Arm Pain | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Epilepsy/Convulsions |
| <input type="checkbox"/> Rt/Lt Numb/ Tingling in Arms/Hands | <input type="checkbox"/> Rt/Lt Hearing Loss | <input type="checkbox"/> Constipation | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Rt/Lt Ringing in the Ears | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Day/Night Incontinence | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Asthma | <input type="checkbox"/> Energy Loss | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Rt/Lt Knee Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Spinal Bone Fracture |
| <input type="checkbox"/> Rt/Lt Foot Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Rt/Lt Numb/ Tingling Legs/Feet | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Arthritis/Joint Pain | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sleep Problems | |

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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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	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Dressing	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Stand up from Sitting	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Climbing Stairs	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Walking	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Sitting for a period of time	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Standing for a period of time	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Sleeping	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Driving	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Concentration (Reading)	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Carrying Groceries	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Lifting Objects	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Playing Sports	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Sweeping/Vacuuuming	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Yard Work	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> Too much pain to do
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Can do but painful	<input type="radio"/> Painful I do with limits	<input type="radio"/> 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	SISTER	BROTHER
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				