Whom may we thank for referring you to this office? ____________________

APPLICATION FOR CARE AT EAST VALLEY CHIROPRACTIC

Today's Date: ____________

HRN: ____________

PATIENT DEMOGRAPHICS

Name: ____________ Birth Date: ____-____-____ Age: ______ ☐ Male ☐ Female

Address: ____________ City: ____________ State: _____ Zip: ________

E-mail Address: ____________ Home Phone: ____________ Mobile Phone: ____________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: ____________

Social Security #: ____________ Driver's License #: ____________

Employer: ____________ Occupation: ____________

Spouse's Name ____________ Spouse's Employer ____________

Number of children and ages: ____________

Name & Number of Emergency Contact: ____________ ____________ Relationship: ____________

INSURANCE INFORMATION

Who is responsible for this account? ____________ Relationship to patient: ____________

Insurance Co: ____________ ID# ____________

Subscriber Name ____________ Birthdate: ____________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: ____________

Secondary: ____________ 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 complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 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? ____________

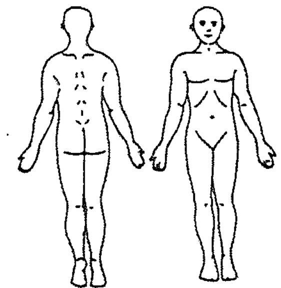
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: ______ by whom? ____________

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 = **R**adiating **B** = **B**urning **D** = **D**ull **A** = Aching **N** = **N**umbness **S** = **S**harp/Stabbing **T** = **T**ingling



What relieves your symptoms? ____________

What makes your symptoms feel worse? ____________

Who is your Primary Care Physician? ____________ Their Location ____________

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

LIFESTYLE CHOICES SELF EVALUATION

Please rate the following on a 1-10 scale with 10 being perfect and 0 being extremely poor.

Exercise ____/10 Diet ____/10 Water Intake ____/10 Sleep ____/10 Stress Management ____/10

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 or **N** for ***Never*** have had:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			
MEDICATIONS			

SOCIAL HISTORY

1. **Smoking:** ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. **Alcoholic Beverage:** consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. **Recreational Drug use:** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. 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
2. **Any** other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ______________________________

I hereby authorize payment to be made directly to East Valley 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 East Valley 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**

PATIENT'S NAME: ______________________________ HR#: ______________ Date: ____________

Functional Rating Index

For use with Neck and/or Back problems only.

In order to properly assess you condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice with most closely describes your condition right now.

1. Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed sleep	Greatly disturbed sleep	Totally Disturbed Sleep

3. Personal care (washing, dressing, etc.)

No Pain No restrictions	Mild Pain No restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe Pain; need 100% assistance

4. Travel (driving, etc)

No Pain On long trips	Mild Pain on long trips	Moderate Pain; on short trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% usual work	Can do 25% usual work	Cannot Work

6. Recreation

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

7. Frequency of Pain

No pain	Occasional Pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ miles	Increased pain after ¼ miles	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Signature X____________________ **Printed Name**____________________ **Date**____/____/____

FAMILY HEALTH HISTORY

Patient Name ____ Date __________________

Please review the below listed symptoms and conditions and indicate those that are <u>current</u> health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a <u>past</u> problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	Father	**Mother**	**Spouse**	**Brother**(s)		**Sister**(s)		**Children**		
	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____	Age____
First Name										
Condition										
Allergies										
Anxiety										
Arthritis										
Auto Accidents										
Back Pain										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Epilepsy										
Frequent Colds/Flus										
Gassy/Bloating										
Headache										
Heartburn										
Heart Trouble										
High Blood Pressure										
Low Energy										
Migraine										
Neck Pain										
Nervousness										
Pinched Nerve										
Scoliosis										
Sinus Trouble										
Sleeping Problems										
Other:										
Other:										
Other:										