T123

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_____

Are you a student? YES NO Have you ever been in the military? YES NO

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

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 ___SEIZURES ___SPINAL BONE FRACTURE ___SCOLIOSIS
___DIABETES ___OSTEOARTHRITIS ___RHEUMATOID ARTHRITIS ___OTHER CONDITIONS/DISEASES

LIST ALL SURGICAL OPERATIONS AND 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: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES TO EITHER OF THE ABOVE, PLEASE DESCRIBE: _____

OTHER TRAUMA: _____

_____

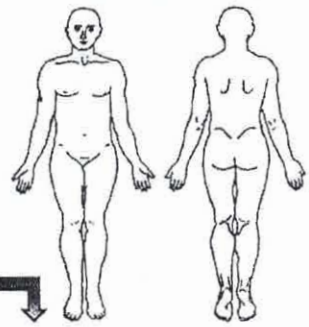
SOCIAL HISTORY

1. SMOKING: How often? □ Daily □ Weekends □ Occasionally □ Never
2. ALCOHOL: How often? □ Daily □ Weekends □ Occasionally □ Never
2. EXERCISE: How often? □ Daily □ Weekends □ Occasionally □ Never
3. How does your present problem affect the following: HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE

_____

_____

*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 Your Current Health Goals Below

HEALTH GOAL	DATE TO ACCOMPLISH	SIGNIFICANCE OF GOAL
Ex: Get rid of my headaches	1/1/2016	I want to play with my kids without pain, be able to spend more time with my family and have more energy.
1.		
2.		
3.		

ACTIVITIES OF DAILY LIVING

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	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Signature: _____ Date____/_____/_____