REFORM | CHIROPRACTIC

Application for Care at **Reform Chiropractic**

Today's Date:_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date:_____-_____-_____ Age: _____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip:_____

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

Do you have Insurance: ☐ Yes ☐ No Are you employed: Yes ☐ No ☐

Social Security #: _____ Occupation: _____

Marital Status: ☐Single ☐Married Spouse DOB___-___-___

Spouse's Name_____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily:_____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 complaints is	: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint	: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint	: 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

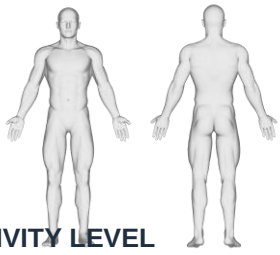
How did the injury happen?_____

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 = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling



What relieves your symptoms? _____
What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

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

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

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 ___Osteoarthritis ___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			

SOCIAL HISTORY(Circle)

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

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 ADIO 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 ADIO 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