



Application for Care at University Chiropractic and Wellness

Today's Date: _____

HRN: _____

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: _____

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 you're 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

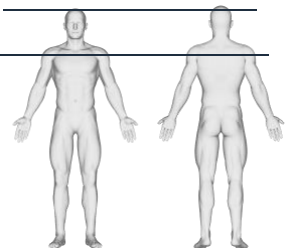
How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

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

Activity level tracking table with three columns: LIST RESTRICTED ACTIVITY, CURRENT ACTIVITY LEVEL, and USUAL ACTIVITY LEVEL. Each row has a vertical ellipsis on the left and horizontal lines for input.



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

- 1. Smoking: cigars pipe cigarettes How often? Daily Weekly Occasionally Never
- 2. Alcoholic Beverage: consumption occurs Daily Weekly Occasionally Never
- 3. Recreational Drug use: Daily Weekly 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 University 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 University 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#: _____ / /