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APPLICATION FOR CARE AT PARTNERSHIP PARK CHIROPRACTIC

Today's Date: _____

PATIENT DEMORAPHICS

Name: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Is it ok to leave messages on your answering machine? ☐ Yes ☐ No

With whom may we leave a message with? _____

Relationship to patient: _____

Choose One: ☐ Minor ☐ Single ☐ Married ☐ Widow

Do you have Medicare? ☐ Yes ☐ No

Do you make your own financial decisions? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Spouse/Guardian: _____

In case of emergency contact: _____ Relationship to patient: _____

Emergency Contact's phone number: _____

Whom may we thank for your referral? _____

HISTORY OF COMPLAINT

List your major complaints in order of severity and please indicate how long you have had each complaint.

1._____

2._____

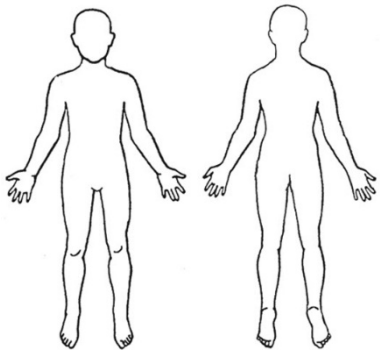
3._____

In regards to your primary complaint:

When did the problem begin? _____

How did the problem begin? _____

Where is the problem? Please indicate on the chart below:



Is there anything that makes the problem **better**? _____

Is there anything that makes the problem **worse**? _____

How would you describe your pain? ☐ Burning ☐ Dull ☐ Achy ☐ Sharp ☐ Numb ☐ Tingly ☐ Tight

Does your pain travel? ☐ Yes ☐ No If yes, where? _____

On a scale of **0** to **10** with **0** being no pain and **10** being the worst pain, rate your paint by circling the number:

1 2 3 4 5 6 7 8 9 10

When is the problem at its worst? ☐ AM ☐ Mid-day ☐ PM ☐ Late PM

Has this problem ever happened before? ☐ No ☐ Yes; **If yes please explain:** _____

_____

Has this condition been treated by anyone recently or in the past? ☐ No ☐ Yes; **If yes,**

When? _____ By whom? _____ How long were you under care? _____

What were the results? _____

What medications are you currently taking? _____

_____

Is there anything else about your problem that is important to know? _____

_____

PAST HEALTH HISTORY (for the following please include: date, type of care received if any and by whom)

Previous chiropractic care: _____

_____

Do you wear a heel lift? ☐ No ☐ Yes; **if yes :** ☐ Right ☐ Left ☐ Both

Auto accidents: _____

_____

Concussions: _____

_____

Additional accidents or injuries in the past year: _____

_____

Any other significant injuries that occurred over 1 year ago: _____

_____

Surgeries or fractures: _____

_____

List all childhood diseases that you have had: _____

_____

List all adult diseases that you have had: _____

_____

Please mark any and all of the problems you currently have or ever have had:

☐ Headache	☐ Pregnant (now)	☐ Dizziness	☐ Prostate problems	☐ Ulcers
☐ Neck pain	☐ Frequent colds/flu	☐ Loss of balance	☐ Impotence/ Sexual dysfxn	☐ Heartburn
☐ Jaw pain/ TMJ	☐ Convulsions/Epilepsy	☐ Fainting	☐ Digestive problems	☐ Heart problem
☐ Shoulder pain	☐ Tremors	☐ Double vision	☐ Colon trouble	☐ High blood pressure
☐ Upper back pain	☐ Chest pain	☐ Blurred vision	☐ Diarrhea/Constipation	☐ Low blood pressure
☐ Mid back pain	☐ Pain w/ cough or sneeze	☐ Ringing in ears	☐ Menopausal problems	☐ Asthma
☐ Low back pain	☐ Fatigue	☐ Hearing loss	☐ Menstrual problems	☐ Difficulty breathing
☐ Hip pain	☐ Sinus problems	☐ Depression	☐ PMS	☐ Lung problems
☐ Foot or knee problems	☐ Swollen/Painful joints	☐ Irritable	☐ Bed wetting	☐ Kidney trouble
☐ Scoliosis	☐ Skin problems	☐ Mood changes	☐ Learning disability	☐ Gall bladder trouble
☐ Numbness/Tingling in arms, hands, fingers		☐ ADD/ADHD	☐ Eating disorder	☐ Liver trouble
☐ Numbness/Tingling in legs, feet, toes		☐ Allergies	☐ Trouble sleeping	☐ Heptitis (A, B, C)

SOCIAL HISTORY

Smoking: ☐ daily ☐ weekends ☐ occasionally ☐ never

Alcoholic beverages: ☐ daily ☐ weekends ☐ occasionally ☐ never

Recreational drug use: ☐ daily ☐ weekends ☐ occasionally ☐ never

Hobbies, recreational activities, exercise routine (please list):

_____

Please describe your diet: _____

_____

Please describe your sleeping habits and sleep quality: _____

_____

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s)? ☐ No ☐ Yes

If yes, what? _____

Whom? ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister ☐ brother ☐ son ☐ daughter

Any other hereditary conditions the doctor should be aware of? _____

_____

TREATMENT GOALS

What are your expectations from receiving and maintaining your spinal correction at Partnership Park Chiropractic? _____

_____

Are you willing to be an active patient in the improvement of your health (ie. Dietary, exercise, and/or lifestyle changes)? ☐ No ☐ Yes

As a result of my chiropractic care, I would like to (please check all that apply):

☐ Feel better quickly ☐ Have a healthier body by keeping my nervous system healthy

☐ Have a healthier spine ☐ Live a healthier lifestyle

What are your top 3 health goals?

1. _____
2. _____
3. _____

I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I acknowledge that I am financially responsible to Partnership Park Chiropractic for any and all services I receive at this office and that payment is due at the time of service.

_____

Patient Name (print)

_____ _____

Patient or Authorized Person's Signature Date