FOUNDATION
chiropractic

APPLICATION FOR CARE AT FOUNDATION HEALTH CHIROPRACTIC

Today's Date: _____

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: _____

May we contact you via text message to keep aware of future appointments? ❑ Yes ❑ No Who is your cell carrier?_____

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

Employer: _____ Occupation: _____

Spouse's Name ❑(N/A)_____Spouse's Employer _____

Who May We Thank For Referring You? _____❑ Mailer ❑TV ❑Internet ❑Dinner ❑ Other:_____

Name & Number of Emergency Contact: _____ _____Relationship: _____

CHIROPRACTIC HISTORY

Science tells us your spine should be cared for regularly. How often do you get adjusted by a chiropractor?
☐ Frequently ☐ only when you hurt ☐ never

When/ and where was your last complete spinal examination including x-rays? _____ _____ ☐ Never

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? ☐ Yes ☐ No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back.
Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Stress will cause you to accelerate spinal damage. Rate your stress level. Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and how they happened:
Primary: _____ Second: _____

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 c***ircling the number***:
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Second complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

What is the level of your pain RIGHT NOW? (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Extreme Pain)

What is the AVERAGE level of your pain? (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Extreme Pain)

What is the level of your pain at it's WORST? (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Extreme Pain)

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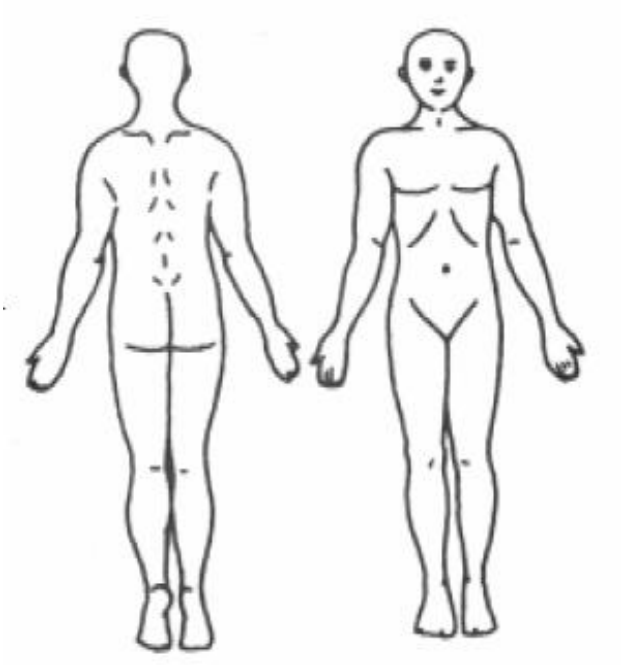

When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM

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

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms?

_____

What makes them feel worse? _____

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

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

_____

If your complaints get in the way of doing things in your life please list those activities below. **C**ondition(s)

LIST AFFECTED ACTIVITIES:	**CURRENT RESTRICTION LEVEL (Time/ Amount)**	**SUCCESS GOAL**
Ex: Driving long distances :	Begins to hurt after 30 Minutes	To drive long distances w/ no pain
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

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?_____

Have you ever been treated by anyone for this in the past? ☐No ☐ Yes **If yes,** when: _____

by whom?_____For how long was the care: _____ How long ago? _____

If yes, please state **what** type of treatment: _____, What were the results.
☐ Favorable ☐ Unfavorable→ please explain. _____

_____

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 and **N** for *N**ever** have had*:

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

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problems

INJURIES / ACCIDENTS →
SURGERIES →
CHILDHOOD DISEASES →
MEDICATIONS (name/reason/how long for each) →

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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. How does your present problem affect the following: **Hobbies -Recreational Activities- Exercise Regime:**

_____

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: _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:
I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at FOUNDATION HEALTH CHIROPRACTIC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ *Witness Initials* Date _____
Patient or Authorized person's Signature

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

******* IF YOU BELIEVE THERE IS A POSSIBILITY YOU MAY BE PREGNANT PLEASE NOTIFY THE DOCTOR OR STAFF PRIOR TO YOUR EXAMINATION******

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to myself *(and/or my unborn child if female)* , and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ *Witness Initials*
Patient or Authorized person's Signature