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 ***circling 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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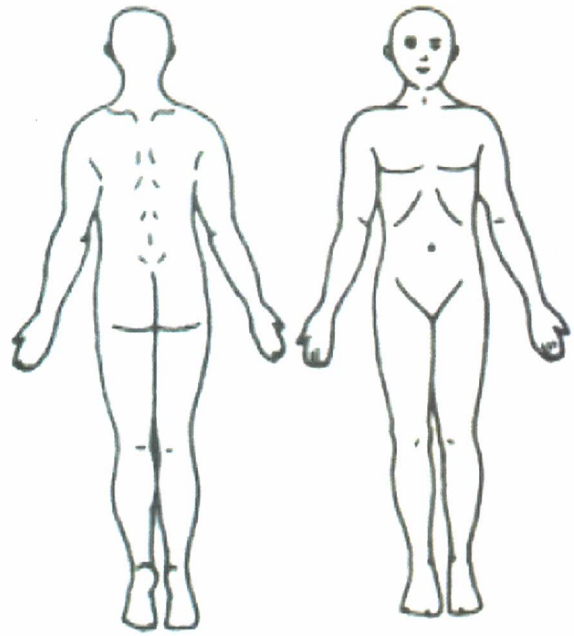

When is the problem at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout 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. Condition(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 ***Never** 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.

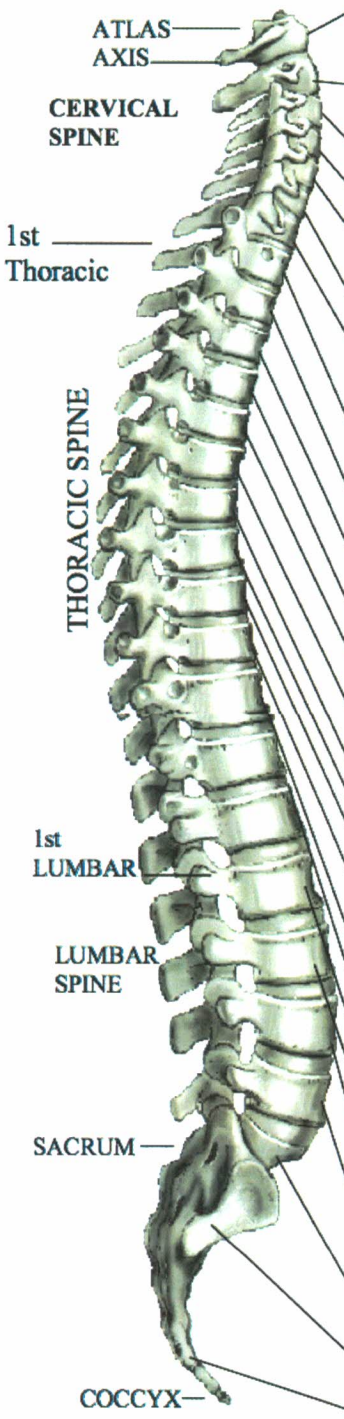
******* IF YOU BELIEVE THERE IS A POSSIBILITY YOU MAY BE PREGNANT PLEASE NOTIFY THE DOCTOR OR STAFF PRIOR TO YOUR EXAMINATION******

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

THE NERVES THAT EXIT THE SPINE SUPPLY LIFE TO EVERY PART OF THE BODY. MISALIGNMENTS PUTTING PRESSURE ON THOSE NERVES CAN CAUSE VARIOUS SYMPTOMS IN THE BODY. PLEASE CHECK ANY CONDITIONS THAT YOU ARE CURRENLY SUFFERING WITH



Vertebrae	Area Controlled *	Possible Effects of Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ **Headaches** ☐ **Migraine Headaches** ☐ Head Colds ☐ High Blood Pressure ☐ Chronic Tiredness ☐ Amnesia ☐ ADD/ADHD ☐ Nervousness ☐ Insomnia ☐ Dizziness
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ Sinus Trouble ☐ Allergies ☐ Pain Around the Eyes ☐ Earaches ☐ Crossed Eyes ☐ Blindness (some) ☐ Deafness ☐ Fainting
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	☐ Neuralgia ☐ Neuritis ☐ Acne / Pimples ☐ Eczema ☐ **Neck Pain, Stiffness, Soreness**
4C	Nose, lips, mouth, Eustachian tube.	☐ Hay Fever ☐ Runny Nose ☐ Swollen Adnoids
5C	Vocal Cords, neck glands, pharynx.	☐ Laryngigitis ☐ Hoarseness ☐ **Hand/Finger Numbness** ☐ Sore Throats ☐ Tonsillitis
6C	Neck muscles, shoulders, tonsils.	☐ **Stiff Neck** ☐ **Pain in Upper Arm** ☐ Chronic Cough ☐ Croup ☐ **Hand/Finger Numbness** ☐ **Shoulder Pain**
7C	Thyroid Gland, bursae in the shoulders, elbows.	☐ Bursitis ☐ Colds ☐ Thyroid Conditions ☐ **Wrist, Hand / Finger Pain or Numbness**
1T	Arms from the elbows down, including hands, wrists, and fingers, esophagus and trachea.	☐ Asthma ☐ Cough ☐ Difficulty Breathing ☐ **Pain into Arms or Hands** ☐ Shortness of Breath
2T	Heart, including its valves and covering, coronary arteries.	☐ Heart Problems ☐ Chest Pain ☐ High Blood Pressure
3T	Lungs bronchial tubes, pleura, chest, breast.	☐ Bronchitis ☐ Pleurisy ☐ Pneumonia ☐ Congestion ☐ Influenza ☐ **Mid Back Pain, Burning, Stiffness, Soreness**
4T	Gallbladder, common duct	☐ Gallbladder Conditions ☐ Jaundice ☐ Shingles
5T	Liver, solar plexus, circulation-general	☐ Liver Conditions ☐ Fevers ☐ Arthritis ☐ Poor Circulation ☐ Other Blood Pressure Problems
6T	Stomach.	☐ Stomach Troubles ☐ Nervous Stomach ☐ Indigestion ☐ Heartburn ☐ Dyspepsia ☐ Nausea
7T	Pancreas, duodenum.	☐ Ulcers ☐ Gastritis ☐ **Mid Back Pain or Burning**
8T	Spleen	☐ Lowered Immune System
9T	Adrenal and Suprarenal glands	☐ Allergies ☐ Hives ☐ **Mid Back Soreness**
10T	Kidneys	☐ Kidney Problems ☐ Pyelitis ☐ Hardening of the Arteries ☐ Chronic Tiredness ☐ Nephritis ☐ **Back Pain**
11T	Kidneys, ureters	☐ Skin Conditions ☐ Pimples ☐ Boils ☐ Acne ☐ Eczema
12T	Small intestines, lymph circulation	☐ Rheumatism ☐ Gas Pains ☐ Certain Types of Sterility
1L	Large intestines, inguinal rings	☐ Constipation ☐ Colitis ☐ Dysentery ☐ Diarrea ☐ Some Hernias ☐ **Back Pain**
2L	Appendix, abdomen, upper leg	☐ Cramps ☐ Difficulty Breathing ☐ Minor Varicose Veins
3L	Sex organs, uterus, bladder, knees	☐ Bladder Problems ☐ Painful or Irregular Periods ☐ Miscarriages ☐ Bed Wetting ☐ Impotency ☐ Change of Life Symptoms ☐ **Knee Pains**
4L	Prostate gland, muscles of the lower back, sciatic nerve	☐ Sciatica ☐ Difficult, Painful, or Too Frequent Urination ☐ **Backaches** ☐ **Pain, Burning or Numbness in Legs**
5L	Lower legs, ankles, feet	☐ Weak Ankles and Arches ☐ Cold Feet ☐ Swollen Ankles ☐ Plantar Fascitis ☐ **Foot Pain** ☐ Weakness in Legs ☐ Leg Cramps ☐ Heel Spurrs ☐ Poor Circulation in Legs
Sacrum	Hip bones, buttocks	☐ **Lower Back Pain into the Hip or Legs** ☐ Spinal Curvature
Coccyx	Rectum, anus	☐ **Pain in Tailbone with Sitting** ☐ Hemorrhoids ☐ Pruritis

NECK REGION · MID-BACK · LOW BACK · PELVIS

*Directly or indirectly controlled.

Patient Signature:_____ Date:_____

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