Whom may we thank for referring you to this office → ____?

APPLICATION FOR CARE AT *Life Essentials Chiropractic*

Today's Date: __________________ HRN: ____________________

PATIENT DEMOGRAPHICS

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

Address: ______________________________________ City: ______________________________ State: _____ Zip: ___________

E-mail Address: _________________________________ Home Phone: __________________________

Mobile Phone: __________________________________

Occupation: ____________________________________ Employer: ____________________________

Health Insurance: ☐ Yes or ☐ No Marital Status: **M S D W**

Name of Spouse: ______________________________ Number of children: ________

Name & Number of Emergency Contact: _______________________________________Relationship: _________________________

HISTORY of COMPLAINT or CONDITION

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

Secondarily: ________________________ Thirdly: __________________________ Fourthly: ______________________________

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 a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is a: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is a: 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? ____

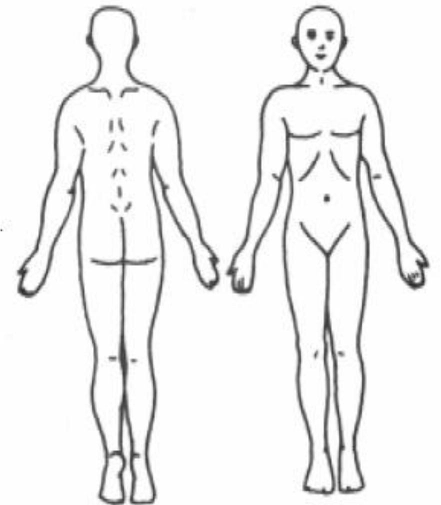
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **if yes,** when: ______ by whom? ____________________________

How long were you under care: ___________ What were the results? ____

Name of Previous Chiropractor: ____________________________ ☐ **N/A**

Did your previous chiropractor take before and after x-rays? ☐ **Yes** ☐ **No**

***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? ____

LIST MOST RESTRICTED ACTIVITIES:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
______________________________:		
______________________________:		
______________________________:		
______________________________:		

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

List any other injuries to your spine, **minor or major**, that the doctor should know about: (Birth, Sports, Falls, Work Activity)

____

____

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 and **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 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 ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect the following:

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 Life Essentials 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 Life Essentials 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#: ______________ ____/____/____

Activities of Daily Living/Symptoms/Medications

Patient Name: ___________________________________ File#____________

Date: ______________________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Care-Family Member	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Change Positions	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Reading or Concentration	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Self Care- Bathing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Self Care- Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Exercise or Recreation	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

HEALTH CONDITIONS:

Spinal distortions and/or misaligned the vertebrae in your spine cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, cause stress to the brain and nervous system, and will weaken and distort the overall structure of your spine creating adverse effects on your overall health. Please mark any health conditions you may be experiencing, now or in the past regardless of the cause.

CERVICAL SPINE (NECK): Please mark P for in the Past, C for Currently have and N for Never____________

Subluxations in the neck weaken the nerves to the arms, hands and head affecting these parts of the body. Do you experience?

____ Neck Pain
____ Headaches
____ Dizziness
____ Thyroid Conditions
____ Visual Disturbances
____ Hearing Disturbances
____ Poor Sleep
____ Convulsions / Epilepsy / Seizures
____ High Blood Pressure
____ Low Blood Pressure
____ Low Energy / Fatigue
____ Anxiety
____ Mood Changes
____ ADD /ADHD
____ Pain Into Your Shoulders / Arms / Hands
____ Numbness / Tingling In Arms / Hands
____ Coldness In Hands
____ Weakness In Grip
____ Sinus Problems
____ Allergies / Hay Fever
____ Recurrent Colds / Flue / Ear Infections

THORACIC SPINE (UPPER BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never ______

Subluxations in the upper back weaken the nerves to the heart and lungs affecting these parts of the body. Do you experience?

____ Heart Palpitations
____ Heart Attacks / Angina
____ Tachycardia
____ Heart Murmurs
____ Recurrent Lung Infections
____ Bradycardia
____ Asthma Wheezing / Shortness Of Breath
____ Recurrent Bronchitis
____ Pain On Deep Inspiration / Expiration

THOPRACIC SPINE (MID BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never_______

Subluxations in the mid back weaken the nerves to the abdomen affecting these parts of the body. Do you experience?

____ Mid Back Pain
____ Nausea
____ Hypoglycemia
____ Kidney Trouble
____ Pain Into Your Ribs / Chest
____ Ulcers / Gastritis
____ Tired / Irritable After Eating Or When You Haven't Eaten For Awhile
____ Gallbladder Trouble
____ Indigestion / Heartburn / Reflux
____ Diabetes

LUMBAR SPINE (LOW BACK): Please mark **P** for in the Past, **C** for Currently have and **N** for Never______

Subluxations in the low back weaken the nerves into your legs and pelvis affecting these parts of the body. Do you experience?

____ Recurrent Bladder Infections
____ Diarrhea
____ Constipation
___ Pain w/ Cough/Sneeze
____ Low Back Pain
____ Muscle Cramps In Your Legs / Feet
____ Sexual Dysfunction
____ Pain Into Your Hips / Legs / Feet
____ Numbness/ Tingling In Your Legs / Feet
____Difficulty Urinating
____ Menstrual Irregularities / Cramping (females)
____ Coldness In Your Legs / Feet
____ Weakness In Lower Extremity

List Prescription & Non-Prescription drugs you take: ____

____

____