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

APPLICATION FOR CARE AT TILTON CHIROPRACTIC & WELLNESS CENTER

Today's Date: _______________ HRN:

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: ____________

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 your 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?______________

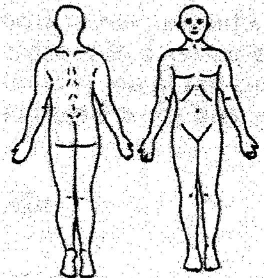
How long were you under care: __________ What were the results? ______________________________

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? ____________________________

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 and **N** for **Never** have had:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture
___ Disability ___Cancer ___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular
___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

BY WHOM	HOW LONG AGO	TYPE OF CARE RECEIVED
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 your present problem affect the following, See pg 2- Activities
5. **Nutrition:** How many Glasses of Water/day: ____ Caffeinated drinks /day: _____ Veggies/day:____

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)
2. Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
3. **Any** other hereditary conditions the doctor should be aware of. ☐ No ☐Yes: ______________________

I hereby authorize payment to be made directly to [CLINIC NAME], 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 [CLINIC NAME] 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#: ______________ ___/___/___ JDD,DC 5/2011

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:

Activity				
Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache
___ Pregnant(Now)
___ Dizziness
___ Prostate
___ Ulcers
___ Neck Pain
___ Frequent Colds
___ Flu
___ Loss of Balance
___ Impotence
___ Sexual Dysfun
___ Heartburn
___ Jaw Pain, TMJ
___ Convulsions
___ Epilepsy
___ Fainting
___ Digestive
___ 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
___ Pain w/ Sneeze
___ Ringing in Ears
___ Menopausal
___ Asthma
___ Low Back Pain

___ Foot/Knee Trouble
___ Hearing Loss
___ Menstrual
___ Difficulty Breathing
___ Hip Pain
___ Sinus/Drainage
___ Depression
___ PMS
___ Lung Problems
___ Back Curvature
___ Swollen Joints
___ Irritable
___ Bed Wetting
___ Kidney Trouble
___ Scoliosis
___ Skin Problems
___ Mood Swing
___ Learning Trouble

___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers
___ ADD/ADHD
___ Eating Trouble
___ Liver Trouble
___ Numb/Tingling legs, feet, toes
___ Allergies
___ Trouble Sleeping
___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take: ______________________________

____

____

TILTON CHIROPRACTIC & WELLNESS CENTER

Patient Name_______________________________________ File#/HRN ____________Date________

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ____

What speed was the collision? ____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe ____________________________________

When was your most recent strain / stress at work? ___________________________________

Please describe the manner of the injury ____________________________________

Was treatment received? Please describe ____________________________________

Does your job require you remain in long term stressful postures?__________________

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____________________________________

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field______________________________________

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

Doctor Signature _________________________________ **Date**___________________ JDD, DC 5/2011