

# APPLICATION FOR CARE AT LIFE SOURCE CHIROPRACTIC

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 #: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work duties: \_\_\_\_\_

Spouse's Name (Parent if pt. is under 18 ) \_\_\_\_\_ Number of children and Ages: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ WOMEN ONLY: Are You pregnant Yes \_\_\_\_\_ NO \_\_\_\_\_

## 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**:

|-----mild-----|-----moderate-----|-----severe-----|

**Primary** or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Second** complaints: : 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? \_\_\_\_\_

**\*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**  
(Circle the letter for the corresponding type of pain below for each condition)

Primary Complaint: **R -- B -- D -- A -- N -- S -- T**

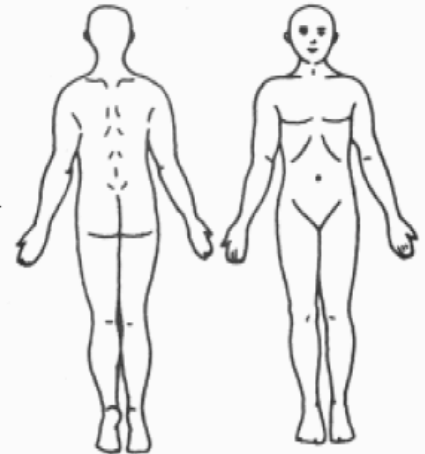
Secondary Complaint: **R -- B -- D -- A -- N -- S -- T**

Third Complaint: **R -- B -- D -- A -- N -- S -- T**

Does the Pain Radiate? \_\_\_\_\_ If Yes, Where?: \_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



**LIST RESTRICTED ACTIVITY:**

**CURRENT ACTIVITY LEVEL**

**USUAL ACTIVITY LEVEL**

\_\_\_\_\_:

\_\_\_\_\_:

\_\_\_\_\_:

\_\_\_\_\_:

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:

	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 your present problem affect the following, See pg. 2- Activities of Life

**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 certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

I hereby authorize payment to be made directly to [LIFE SOURCE CHIROPRACTIC](#) for all benefits which may be payable under a healthcare plan or from any other collateral sources.

\_\_\_\_\_  
**Patient or Authorized Person's Signature** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
**Date Form Reviewed**

**Patient's Name:** \_\_\_\_\_ **HR#:** \_\_\_\_\_ / /

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ HRN: \_\_\_\_\_

**PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING:**

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Headache                                     | <input type="checkbox"/> Pregnant (Now)              | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Prostate Problems            | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Neck Pain                                    | <input type="checkbox"/> Frequent Colds/Flu          | <input type="checkbox"/> Loss Of Balance     | <input type="checkbox"/> Impotence/Sexual Dysfunction | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Jaw Pain/TMJ                                 | <input type="checkbox"/> Convulsions/Epilepsy        | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Digestive Problems           | <input type="checkbox"/> Heart Problem        |
| <input type="checkbox"/> Shoulder Pain                                | <input type="checkbox"/> Tremors                     | <input type="checkbox"/> Double Vision       | <input type="checkbox"/> Colon Trouble                | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Upper Back Pain                              | <input type="checkbox"/> Chest Pain                  | <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Diarrhea/Constipation        | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Mid Back Pain                                | <input type="checkbox"/> Pain with a Cough or Sneeze | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Menopausal Problems          | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Low Back Pain                                | <input type="checkbox"/> Foot or Knee Problems       | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Menstrual Problems           | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain                                     | <input type="checkbox"/> Sinus/Drainage Problem      | <input type="checkbox"/> Depression          | <input type="checkbox"/> PMS                          | <input type="checkbox"/> Lung Problem         |
| <input type="checkbox"/> Back Curvature                               | <input type="checkbox"/> Swollen/Painful Joints      | <input type="checkbox"/> Irritable           | <input type="checkbox"/> Bed Wetting                  | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Scoliosis                                    | <input type="checkbox"/> Skin Problems               | <input type="checkbox"/> Mood Changes        | <input type="checkbox"/> Learning Disability          | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Broken Bone                                  | <input type="checkbox"/> Cerebral Vascular Problem   | <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Eating Disorder              | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Dislocation                                  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Trouble Sleeping             | <input type="checkbox"/> Hepatitis (A, B, C)  |
| <input type="checkbox"/> Numbness/Tingling in Arms, Hands, or Fingers |  | <input type="checkbox"/> Disability          | <input type="checkbox"/> Tumor                        | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Numbness/Tingling in Legs, Feet, or Toes     |  | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Osteoarthritis       |

**AFFECTS OF DAILY LIVING: EFFECTS OF CURRENT CONDITIONS ON PERFORMANCE**

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

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please list any supplements, current prescription and nonprescription medications you are taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_