***Whom may we thank for referring you to this office? 🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**WELCOME TO ACTIVE LIFE 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 c***ircling 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 problem happen?\_\_\_\_\_\_\_\_\_\_\_\_**

**C**ondition(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 = R**adiating **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When your problem is at its worse does it restrict you from any daily activities?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 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 whoprovided 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*** haveand **N** for *N****ever*** *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 🡪** |

**Please List all prescription medications that you are currently taking:**

**SOCIAL HISTORY**

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes 🡪 How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. Alcoholic** **Beverage**: consumption occurs 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**3. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect your problem?

**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 Active Life 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 Active Life 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**