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:_____ Work Phone: _____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No

Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Height _____ Weight _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: First:_____
Second: _____ Third: _____
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 complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint 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

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** ▫ It is on and off during the day **OR** ▫ It comes and goes throughout the week

How did the problem happen?_____

Has this condition(s) ever been treated by anyone in the past? ▫ No ▫ Yes

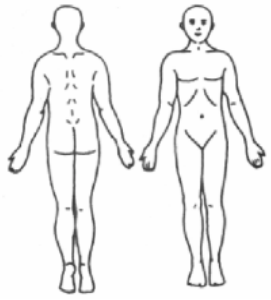
If yes, when?: _____ by whom?: _____

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 = **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?

_____

_____

_____

_____

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:
_____ Who provided it?: _____ How long ago? _____
What were the results? ☐ Favorable ☐ Unfavorable → if so, 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 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 these things?

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**