APPLICATION FOR CARE FIRST STEP CHIROPRACTIC & FAMILY WELLNESS

Today's Date: _____

PATIENT DEMOGRAPHICS

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

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Work Phone: _____Do you have Insurance: ❑ No ❑ Yes *Primary Insured DOB*_____ Marital Status: ❑ Single ❑ Married

# of children: _____ Names/Age: _____/_____ _____/_____ _____/ _____

May we contact you via text message to keep aware of future appointments? ❑ Yes ❑ No Who is your cell carrier?_____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name ❑(N/A)_____Spouse's Employer _____

Who May We Thank For Referring You? _____❑ Mailer ❑TV ❑Internet ❑Dinner ❑ Other:_____

Name & Number of Emergency Contact: _____ _____Relationship: _____

CHIROPRACTIC HISTORY

When/ and where was your last complete spinal examination including x-rays? _____ _____ ☐ Never

Over time spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back. Do you hear these sounds when you move your head or neck? ☐ Yes ☐ No

If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back. Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

Poor posture leads to poor health and early death. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Stress will cause you to accelerate spinal damage. Rate your stress level. Relaxed 1 2 3 4 5 6 7 8 9 10 Very tense/Tight

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and how they happened:

Primary: _____ _____ Second: _____ _____

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 When did the problem begin? _____

Second complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

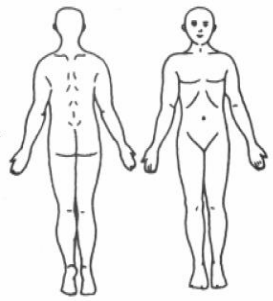
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 When did the problem begin? _____

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

***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? _____

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

Please identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

If your complaints get in the way of doing things in your life please list those activities below. **C**ondition(s)

LIST AFFECTED ACTIVITIES:	CURRENT RESTRICTION LEVEL (Time/ Amount)	SUCCESS GOAL
Ex: Driving long distances :	Begins to hurt after 30 Minutes	To drive long distances w/ no pain
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

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?_____

Have you ever been treated by anyone for this in the past? ☐No ☐ Yes **If yes,** when: _____

by whom?_____For how long was the care: _____ How long ago? _____

If yes, please state **what** type of treatment: _____, What were the results.
☐ Favorable ☐ Unfavorable→ please explain. _____
_____

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 problems

INJURIES / ACCIDENTS →
SURGERIES →
CHILDHOOD DISEASES →
MEDICATIONS (name/reason/how long for each) →

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. How does your present problem affect the following: **Hobbies -Recreational Activities- Exercise Regime:**

_____

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 First Step 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 First Step Chiropractic for any and all services I receive at this office. **The above information is true and accurate to the best of my knowledge.**

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ HR#: _____ ___/___/___