APPLICATION FOR CARE AT DICKASON CHIROPRACTIC

Whom may we thank for referring you to this office → _____

Today's Date: _____

PATIENT DEMOGRAPHICS

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

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

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

Mobile Phone: _____ Work Phone: _____ Fax: _____

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

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____Spouse's Birth Date_____

Occupation: _____ Names and Ages of your children: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

Primary problem _____ 2nd _____ 3rd _____ 4th_____

When did each **problem/symptom begin**: Primary complaint _____ 2nd _____ 3rd_____ 4th_____

Number of times you have experienced: Primary complaint _____ 2nd _____ 3rd_____ 4th_____

When was the last **episode**? Primary complaint _____ 2nd _____ 3rd_____ 4th_____

What relieves your symptom(s)? Primary complaint _____ 2nd _____ 3rd_____ 4th_____

What makes them feel worse? Primary complaint _____ 2nd _____ 3rd_____ 4th_____

Please mark with a "**C**" if you feel your pain constantly or an "**I**" if you experience it intermittently on the line next to each compliant:

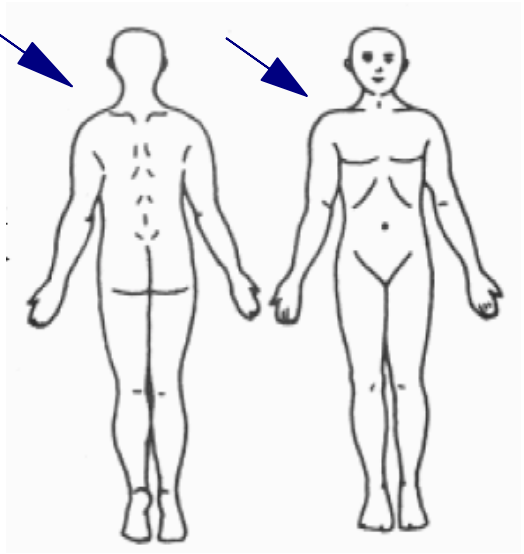
Primary problem ___ 2nd ___ 3rd ___ 4th ___

On a scale of **1 to 10** with**10** being the worst pain and **0** being no pain, rate how you feel today ***(Circle the number)*:**

Primary or chief complaint	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

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



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**

Who provided: _____

How long ago? _____What **type** of treatment did you receive? _____

What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:

_____

List any **medications** taken to treat these conditions:_____

Did they help? ☐ No ☐ Yes If you still take them how often? _____

Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____

Name of Previous Chiropractor: _____

Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**

How long ago? _____ Please explain what type of accident: _____

PAST HISTORY

1. 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:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure

___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis

___ Osteo Arthritis ___ Fracture ___Diabetes ___ Other serious conditions

2. PLEASE**, identify** ALL PAST **and any** unrelated current **conditions you feel may be contributing your present problem:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS →			
ADULT DISEASES →			
SURGERIES →			
CHILDHOOD DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → how often?	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never
2. Alcoholic Beverage: consumption occur →	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never
3. Recreational Drug use:	❑ Daily	❑ Weekends	❑ Occasionally	❑ Never
4. How many years of school did you complete? ❑ 1-8	☐ 8-12	☐12-14	☐14-16	☐ 16 +

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 _____ _____

_____ ACTIVITIES /HOBBIES			**EFFECT: _____ _____**	
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lying to sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pulling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exercise regime	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Tie shoes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Hobbies (please state)	☐ No Effect	☐ Painful /can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types o complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and althoug rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per on million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted at this by the doctor(s) i practice all my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of a risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the docto deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Comp**leted**

_____

Reviewed by: ❑ **Interviewer Initials** ❑ **Doctors Initials**

Reserved for doctor's use only → Systems reviewed with patient:
❑Musculoskeletal
❑Neurological
❑ _____