APPLICATION FOR CARE AT NORTHSTAR CHIROPRACTIC AND WELLNESS

PATIENT DEMOGRAPHICS

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

Address: _____ City: _____ State: _____ Zip: _____ Apt#: _____

E-mail: _____ Home Phone: _____ Cell Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other Spouse's Name (if applicable): _____

Number of Children: _____ Emergency Contact Name & Phone: _____

Employer: _____ Occupation: _____

Who Can We thank For Referring You, Or How Did You Hear About Our Office? _____

Do you have health insurance: ❑ No ❑ Yes Insurance Company: _____

HISTORY OF COMPLAINT(S)

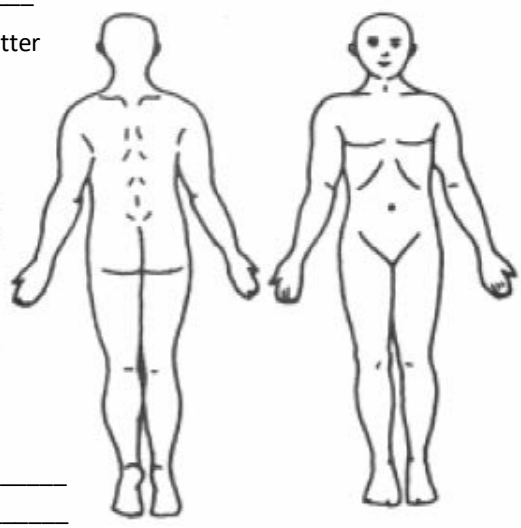
Please identify the condition(s) that brought you to this office, and rank them on a scale of 0 to 10 by c*ircling the number*:

Primary Complaint: _____

- Severity: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe Pain)
- Problem Occurs: ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Infrequently
- When did the problem(s) begin? _____
- How did this happen? _____
- Since this problem began, is it: ☐ Getting worse ☐ Staying the same ☐ Getting better
- When is it the worst? ☐ AM ☐ Mid-day ☐ PM

Secondary Complaint(s): _____

- Severity: (No Pain) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe Pain)
- Problem Occurs: ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Infrequently
- When did the problem(s) begin? _____
- How did this happen? _____
- Since this problem began, is it: ☐ Getting worse ☐ Staying the same ☐ Getting better
- When is it the worst? ☐ AM ☐ Mid-day ☐ PM



****Please mark on the body 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 **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Please list all medications and supplements you take: _____
_____
_____

Patient Name: _____ **Date:** _____

PAST AND CURRENT HEALTH CONDITIONS - Mark Any Conditions That Apply: P for **Past, C** for **Current**

___ Headache	___ Chest Pain	___ Dizziness	___ Broken/Fractured Bones	___ Swollen/Painful Joints
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Rheumatoid Arthritis	___ High Blood Pressure
___ Jaw Pain, TMJ	___ Difficulty Breathing	___ Concussion	___ Osteoarthritis	___ Heart Disease
___ Shoulder Pain	___ Pain in Ribs	___ ADD/ADHD	___ Knee/Foot Pain	___ Diabetes
___ Upper Back Pain	___ Pain w/Cough/Sneeze	___ Blurred Vision	___ Allergies	___ Thyroid Problems
___ Mid-Back Pain	___ Asthma	___ Ringing in Ears	___ Fatigue	___ Liver Problems
___ Low Back Pain	___ Fibromyalgia	___ Hearing Loss	___ Difficulty Concentrating	___ Gallbladder Problems
___ Hip Pain	___ Digestive Issues	___ Depression	___ Lyme's Disease	___ Menstrual/Prostate Problems
___ Scoliosis	___ Cancer	___ Poor Sleep	___ Numbness/Tingling in arms, hands, fingers	
___ Numbness/Tingling in legs, feet, toes		___ Other injuries / illnesses: _____		

ACTIVITIES OF DAILY LIVING - Please List Any Activities That May Be Restricted Due To Current Condition(s)

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting / Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Completing Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sports / Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Computer Work / Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

HEALTH HABITS:

Exercise Frequency: ❑ 0 – 1x Wk ❑ 2 – 3x Wk ❑ 4+ Wk Has this changed due to your current complaints? ❑ No ❑ Yes

Water Intake: ❑ 0 – 3 Glasses Daily ❑ 4 – 8 Glasses Daily ❑ 8+ Glasses Daily

Daily Intake of Fresh Fruits & Vegetables: ❑ 0 – 2 Servings ❑ 3 – 5 Servings ❑ 6+ Servings

Beverage Consumption (soda, energy drinks, sports drinks, etc.): ❑ Multiple Times Daily ❑ Daily ❑ Occasionally ❑ Never

Smoking Tobacco: ❑ Daily ❑ Occasionally ❑ Never

Alcoholic Beverage: ❑ Daily ❑ Occasionally ❑ Never

Recreational Drug use: ❑ Daily ❑ Occasionally ❑ Never

Patient Name: _____ **Date:** _____

PAST HISTORY

Have you ever been treated for similar conditions by other healthcare providers in the past? ☐ No ☐ Yes If yes, when: _____

By whom? _____ What type of treatment? _____

How long were you under care: _____ What were the results? ☐ Favorable ☐ Unfavorable

Have you ever been in an auto accident? ❑ No ❑ Yes If yes, how many? _____ Date of last accident: _____
What was the approximate speed of the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? ❑ No ❑ Yes If yes, what: _____

Have you ever had spine, hip, knee, or foot surgeries? ❑ No ❑ Yes If yes, please list: _____

Please list any other injury(s) or occupational hazards that impose physical stress on your spine, minor or major, that the doctor should know about (Examples: Slips/falls, past sports injuries, concussions, whiplash, repetitive motions at work, heavy lifting, etc.)

_____

_____

HEALTH GOALS FOR CARE IN OUR OFFICE:

Please list your current health goals or additional ways we can help (check all that apply):
☐ Get out of pain ☐ Achieve/Maintain optimal health ☐ Weight loss ☐ Improve nutrition ☐ Improve energy levels
☐ Other: _____

If necessary based on your exam findings, how willing are you to perform 5-10 minutes of daily home spinal exercises to help improve your condition? ☐ 100% Committed ☐ Will try to perform daily ☐ Might consider doing home exercises ☐ Not likely to do them

What is your biggest reason for seeking care in our office, or what can we help you achieve that is currently limited by your health?

_____

_____

RELEASE OF INFORMATION:

In accordance with all HIPPA guidelines regarding privacy of patient information and medical records, I understand that my medical information will not be released to anyone without prior written consent. The information listed on these forms are accurate to the best of my knowledge. I authorize utilization of this application or copies thereof for the purpose of processing insurance and medical claims, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability for all uncovered services.

Do you wish to release medical records to any friends or family members? ❑ No ❑ Yes If yes, who: _____

_____ _____
Patient Signature Date

INFORMED CONSENT REGARDING: Chiropractic Exams, Adjustments, Therapeutic Procedures, and X-Rays

Chiropractic care, like all forms of health care, may hold certain risks. Chiropractic treatments are shown to be very safe and effective, and risks are most often minimal, such as muscle soreness following treatments. More significant health risks such as fractures, stroke, muscle contusion, etc. are extremely rare. I understand that there are also risks with exposure to x-rays. After consideration, I do hereby consent to chiropractic treatments, and/or diagnostic x-ray examinations deemed necessary by the doctor.

Women Only:
☐ To the best of my knowledge, I am not currently pregnant.
☐ I am, or may currently be, pregnant and consent to chiropractic exams and treatments

_____ _____
Patient Signature Date

_____ _____
If under 18, Parent or Legal Guardians Signature Date