

**APPLICATION FOR CARE**

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

**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 Insurance Company: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Phone: \_\_\_\_\_

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: **Primary:** \_\_\_\_\_

**Secondary:** \_\_\_\_\_ **Third:** \_\_\_\_\_ **Fourth:** \_\_\_\_\_

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

**Primary** or chief 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 is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Fourth** complaint is: 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 injury happen? \_\_\_\_\_

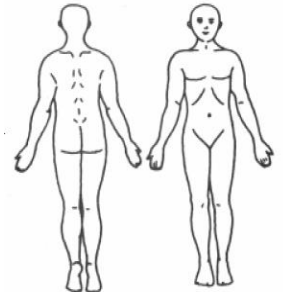
Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_

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 = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling**



What relieves your symptoms? \_\_\_\_\_

What makes your symptoms feel worse? \_\_\_\_\_

**LIST RESTRICTED ACTIVITY:**

**CURRENT ACTIVITY LEVEL**

**USUAL ACTIVITY LEVEL**

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

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 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? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state **what** type of treatment: \_\_\_\_\_, and who provided 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** have or **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 problem:**  
If these condition does not apply to you, please label N/A on each column.

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

**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. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

**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 **Primero Spine + Joint** 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 **Primero Spine + Joint** for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_-\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_-\_\_\_\_\_  
**Date Form Reviewed**

Name: \_\_\_\_\_ DOB: / / \_\_\_\_\_ HRN#: \_\_\_\_\_

### ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

### REVIEW OF SYSTEMS

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

<input type="checkbox"/> Headache	<input type="checkbox"/> Pregnant (Now)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Impotence/Sexual Dysfun.	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Jaw Pain, TMJ	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Heart Problem
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Tremors	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pain w/Cough/Sneeze	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Menopausal Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Foot or Knee Problems	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Menstrual Problem	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sinus/Drainage Problem	<input type="checkbox"/> Depression	<input type="checkbox"/> PMS	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Numb/Tingling arms, hands, fingers	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Numb/Tingling legs, feet, toes			<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Hepatitis (A,B,C)

**Patient signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_