To whom may we thank for referring you to our office? ________________________________

APPLICATION FOR CARE AT HOMETOWN CHIROPRACTIC

Today's date:___/____/_____

Patient Demographics:

Name:____ Birth date: ____/____/____
Age:________ ☐ Male ☐ Female
Address: ____ City: ________________________
State: ______ Zip:_________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Do you have health insurance? ☐ No ☐ Yes ____
Cell number _____________________________ Work number __________________________
Social Security #__________________________
Occupation/Employer:____
Spouse's Name: ____________________________ Spouse's Occupation__________________
Number of children & ages:____
Emergency Contact Name & Number ____
Relationship to Contact: ____

History of Complaint:

Please identify the complaint/s that bring you to our office:
Primary ____________________________Secondary ____________________________
Third: __________________________ Fourth:_________________________________

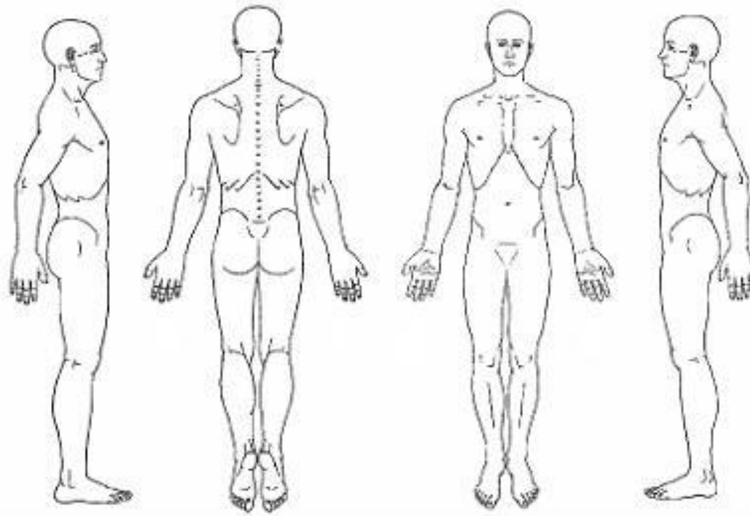
On a scale of 1 to 10, **10 being the most severe and 0 being no pain**, rate your above complaints by circling the number:

Primary	0	1	2	3	4	5	6	7	8	9	10
Secondary	0	1	2	3	4	5	6	7	8	9	10
Third	0	1	2	3	4	5	6	7	8	9	10
Fourth	0	1	2	3	4	5	6	7	8	9	10

When did the complaint/s begin? (Date)____
When is the complaint at its worst? ☐ AM ☐ PM ☐ Mid-day ☐ Late evening ☐ Varies
How did the problem/s start?:
____
____
Have you been treated by anyone else for the previous complaint/s? ☐ Yes ☐ No
If yes, by who?: ____
How long were you under care? ____________________ Was it helpful? ☐ Yes ☐ No

Have you been to the Chiropractor before? □ No □ Yes Dr. ______________________________
Please mark the areas on the diagram with the following letters to describe your symptoms:

A= Aching
B= Burning
R= Radiating
N= Numbness
T= Tingling
S= Sharp
X= Tight/stiff



What relieves your symptoms?: ____
What makes your symptoms feel worse? ____
Any injuries in the past , both major and minor, that the doctor should know about?
____
____
____
____

Past History:
Have you experienced a similar type of complaint in the past? □ No □ Yes
If yes, when was the last episode?____
How did the injury happen?____
What other treatment options did you try? ____________________________________

Have you held previous jobs that have imposed any physical stress on your body? If yes, please list them ____

If you have been medically diagnosed with any of the following conditions, please indicate a **P** for past, **C** for current, or **N** for never:

____Fracture	____Dislocations	____Tumors	___Rheumatoid Arthritis
____Disability	____Cancer	____Heart Attack	___Osteoarthritis
____Scoliosis	____Diabetes	____Seizures	___Hypertension
____Depression	____Anxiety	____Psoriasis	___ Lupus
____Concussion	____Crohns/UC	____Incontinence	___Disc Herniation

Please list any past injuries, diseases or surgeries you think may be contributing to your current complaint/s:

Injury, Surgery, or Disease	*How long ago?*	*Treatment received?*	*By whom?*

Social History:

1. Smoking: ☐ Cigars ☐ Cigarettes ☐ Pipe ☐ Daily ☐ Occasional ☐ Never
2. Alcohol: Drinking occurs ☐ Daily ☐ Occasional ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Occasional ☐ Never
4. Physical activity: ☐ Daily ☐ Occasional ☐ Never
    a. Type of activity: ____
5. Diet: ☐ Balanced ☐ Restricted ☐ Intolerance to _____________________________

Family History:

Please check all of the following that apply to your family's medical history:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Alzheimer's ☐ Dementia
☐ Alcoholism ☐ Depression ☐ Cancer ☐ Osteoarthritis ☐ Scoliosis
☐ Obesity ☐ Thyroid dysfunction ☐ Digestive issues
☐ Other/s: ____

I hereby authorize payment to be made to ***Hometown Chiropractic Spring Arbor PLLC****, 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 acknowledgement that this assignment of benefits does not relieve me of payment liability, and that I will remain financially responsible to* ***Hometown Chiropractic Spring Arbor PLLC*** *for any and all services I receive at this office.*

Patient/authorized person's signature ________________________________Date: ___/___/_____

Doctor's Signature____ Date: ___/____/____

Patient's name _________________________________File #_______________Date: ___/____/___