APPLICATION FOR CARE AT MOSS FAMILY 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: _____Cell Phone:_____

Marital Status: **Married Widowed Divorced Single** Work Phone: _____

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

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Names and ages of your children:_____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: (01) Primarily: _____

Secondarily: _____ 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*****:** (14)

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 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

When did the problem(s) begin? _____ (6) When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM (10)
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? (08)_____

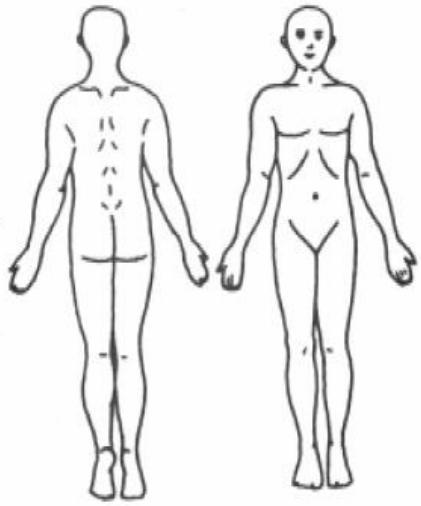
_____

Name of Previous Chiropractor: _____ ☐ **N/A**

***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? (12) _____

What makes them feel worse? (11) _____

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 (105) **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*** experiencing, and **N** for *N**ever** have had***:**
___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions (09):

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

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never (114)
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never (117)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister ❑ brother ❑ 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: _____
_____

PATIENT AUTHORIZATION

I hereby authorize payment to be made directly to Moss Family 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 Moss Family Chiropractic for any and all services I receive at this office.

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

_____ _____ - _____ - _____
Patient's Name **Date of Birth**

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

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ **Date:** _____

Daily Activities: Effects of Current conditions On Performance (15)

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

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Concentrating	☐ No Effect	☐ slightly difficult	☐ moderately difficult	☐ Unable to Perform	☐ N/A
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Playing with my kids	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform	☐ N/A

Initials

INITIAL NERVE SYSTEM PROFILE

Patient Name: _____ **Date:** _____

When was your most recent auto accident? _____
What speed was the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____
Please describe the manner of the injury _____
Was treatment received? Please describe _____
Does your job require you remain in long term stressful postures? (*i.e. all day seating, repeated lifting, long term computer use) Yes No*

Spinal traumas in the past:
Did you play collision, quick burst, or repetitive motion sports such as football, wrestling, basketball, baseball, soccer, tennis, golf, track and field Yes / No If yes, which sport(s)?_____
Trauma as a child? i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident Yes / No If yes, what happened?_____
Work around the house – lifting, bending, woke up with stiff neck, "back went out" Yes / No

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Please mark P for in the **Past, C** for **Currently** have and **N** for **Never** (118)

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

List Prescription & Non-Prescription drugs you take: (108) **List any Vitamins and Supplements you take**: (109)

_____ _____

_____ _____

_____ _____

_____ _____

Initials