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PRACTICE MEMBER APPLICATION

Name: _____ Email Address: _____

If practice member is a minor, parent name(s): _____

Date of Birth: _____/_____/_____ Age: _____ Male / Female Today's Date: _____/_____/_____

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

Cell Phone: _____ Cell Provider: _____ Home: _____

Occupation: _____; Student / Retired / Full Time Parent

Employer's Name: _____

Marital Status: S M D W Spouse's Name: _____ Number of Children: _____

Names, Ages & Gender: _____

_____

__WOMEN ONLY__ *For x-ray purposes, is there any possibility that you could be pregnant? YES / NO*

If yes, how far along? _____ Due Date: _____

Who may we thank for referring you? _____

WHAT BRINGS YOU IN TODAY? PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	**Rate of Severity 1 = mild 10 = unbearable**	**When did this episode start?**	**If you had the condition before, when?**	**Did the problem begin with an injury?**	**Is this problem constant or intermittent?**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

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HOW DO YOUR CURRENT HEALTH PROBLEMS AFFECT YOUR FAMILY LIFE, WORK, HOBBIES, ETC…?

_____

_____

_____

HAVE YOU PREVIOUSLY SEEN A CHIROPRACTOR? YES / NO

IF YES, DR. NAME AND LOCATION: _____

DATE OF LAST ADJUSTMENT:_____

DATE OF LAST SPINAL X-RAYS:_____

HAVE YOU SEEN ANY MEDICAL DOCTORS FOR THESE CONDITIONS? YES / NO

IF YES, WHEN AND FOR WHICH CONDITION(S)?_____

_____

LIST ALL SURGICAL OPERATIONS AND YEARS:

_____

_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU TAKE / LAST ROUND OF ANITBIOTICS (DATE)

_____

_____

_____

LIST ALL TRAUMAS (AUTO ACCIDENTS, SLIPS, FALLS, SPORTS, EXERCISE) AND DATES:

_____

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

DID YOU RECEIVE ANY MEDICAL TREATMENT PERTAINING TO THE ACCIDENT? YES / NO

IF YES, WHAT TREATMENT OR IMAGING DID YOU RECEIVE?_____

_____

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HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO **FRACTURED A BONE? YES / NO**

IF YES, PLEASE DESCRIBE: _____

SOCIAL HISTORY | DO YOU…

SMOKE? YES / NO HOW OFTEN? _____

EXERCISE? YES / NO HOW OFTEN? _____ MILD / MODERATE / INTENSE

DRINK ALCOHOL? YES / NO HOW MANY DRINKS?_____ HOW OFTEN?_____

CIRCLE ANY CONDITION YOU HAVE NOW OR HAVE HAD IN THE PAST:

STROKE	CANCER	HEART DISEASE	SPINAL SURGERY
SEIZURES	SPINAL BONE FRACTURE	DIABETES	SCOLIOSIS

CIRCLE ALL *CURRENT* PROBLEMS YOU HAVE:

DIZZINESS/VERTIGO	**ASTHMA**	**MID BACK PAIN**	**LOW BACK PAIN**	**DISC PROBLEMS**
HEADACHES	**ALLERGIES**	**NUMBNESS IN ARMS**	**NUMBNESS IN LEGS**	**HIP/PELVIC PAIN**
NECK PAIN	**EAR INFECTIONS**	**NUMBNESS IN HANDS**	**NUMBNESS IN FEET**	**SCIATICA**
VISION CHANGES	**FREQUENT COLDS**	**SHORTNESS OF BREATH**	**BLADDER PROBLEMS**	**LEG PAIN**
NAUSEA	**SINUS ISSUES**	**CHEST PAIN**	**CONSTIPATION/DIARRHEA**	**KNEE PAIN**
ANXIETY	**RINGING IN EARS**	**HEART DISORDERS**	**MENSTRUAL PROBLEMS**	**IBS/CROHN'S**
DEPRESSION	**AUTISM SPECTRUM**	**INFERTILITY/MISCARRIAGE**	**POOR CONCENTRATION**	**MUSCLE WEAKNESS**
NERVOUSNESS	**THYROID ISSUES**	**SHOULDER PAIN**	**KIDNEY PROBLEMS**	**MUSCLE SPASMS**
EPILEPSY/SEIZURES	**TMJ / JAW PAIN**	**ARM PAIN**	**CHRONIC FATIGUE**	**FIBROMYALGIA**
ADD/ADHD	**INSOMNIA**	**DIGESTIVE ISSUES**	**LIVER DISEASE**	**SCOLIOSIS**
ARTHRITIS	**ECZEMA/RASH**	**ACID REFLUX/ULCERS**	**HIGH/LOW BLOOD PRESSURE**	

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FAMILY HISTORY

CONDITION	MOTHER	FATHER	CHILDREN	SPOUSE
Anxiety/Depression				
Arthritis				
Asthma/Allergies/Sinus Trouble				
ADD/ADHD/Autism				
Bed Wetting				
Cancer				
Deceased				
Diabetes				
Digestive Problems/Heartburn				
High or Low Blood Pressure				
Ear Infections				
Fibromyalgia				
Fertility Problems				
Headaches/Migraines				
Neck Pain/Back Pain/Disc Problems				
Menstrual Problems				
Scoliosis				
TMJ Dysfunction				

Do any of your friends or relatives see a chiropractor? YES NO

If yes, do they use chiropractic for: **HEALTH OPTIMIZATION** **HEALTH PROBLEMS** **BOTH**

Is your child seeking chiropractic for: **HEALTH OPTIMIZATION** **HEALTH PROBLEMS** **BOTH**

What would you like to gain from chiropractic care?_____

_____

I certify that the information contained on this application is filled out to the best of my knowledge.

_____

PRACTICE MEMBER NAME DATE