Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT Ancient City Chiropractic

NP ENGLISH 2021-07 Email

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name_____ Birth Date: _____-_____-_____ Age: _____ o Male o Female

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

E-mail Address: _____Home Phone: _____Mobile Phone:_____

Marital Status: ___Single ___Married Do you have Insurance: __Yes __No Work Phone: _____

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

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

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: 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*:**

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: 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? _____ 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?_____

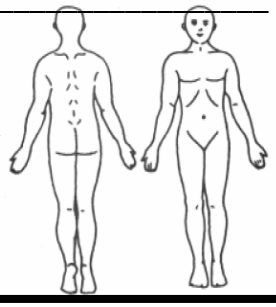
Condition(s) ever been treated by anyone in the past? ☐No ☐Yes **If yes,** when: _____ by whom? _____

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= B**urning **D =D**ull **A =** Aching **N = N**umbness **S =S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your Is Is your problem the result of ANY type of accident? ___Yes, ___No

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._____
_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently***haveand **N** for *N**ever** 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:

	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

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? q No q Yes
If yes whom:q grandmother q grandfather q mother q father q sister's q brother's q son(s) qdaughter(s)
Have they ever been treated for their condition? q No q Yes qI don't know
2. Any other hereditary conditions the doctor should be aware of. q No ❑Yes: _____

Please list the **3 Most Important People/Things** in your life:

1. _____
2. _____
3._____

I hereby authorize payment to be made directly to Ancient City Chiropractor 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 Accurso Chiropractic for any and all services I receive at this office.

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

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

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ File#_____ **Date:** _____

Daily Activities: Effects of Current conditions On Performance

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
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	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
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Patient Name_____ File#/HRN _____Date_____

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

___ Headache
___ Neck Pain
___ Jaw Pain, TMJ
___ Shoulder Pain
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Hip Pain
___ Back Curvature
___ Scoliosis
___ Numb/Tingling arms, hands, fingers
___ Numb/Tingling legs, feet, toes
___ Foot/Knee Problems
___ Swollen/Painful Joints
___ Skin Problems

___ Pregnant (Now)
___ Frequent Colds/Flu
___ Convulsions/Epilepsy
___ Tremors
___ Blurred Vision
___ Pain w/Cough/Sneeze
___ Sinus/Drainage Problem
___ Allergies
___ Difficulty Breathing
___ Asthma
___ Learning Disability
___ ADD/ADHD
___ Eating Disorder
___ Trouble Sleeping

___ Dizziness
___ Loss of Balance
___ Digestive Problems
___ Double Vision
___ Diarrhea/Constipation
___ Ringing in Ears
___ PMS
___ Menstrual Problem
___ Menopausal Problems
___ Depression
___ Irritable
___ Mood Changes
___ Impotence/Sexual Dysfun.
___ Fainting

___ Prostate Problems
___ Chest Pain
___ Heart Problem
___ High Blood Pressure
___ Low Blood Pressure
___ Heartburn
___ Hearing Loss
___ Lung Problems
___ Bed Wetting
___ Ulcers
___ Kidney Trouble
___ Gall Bladder Trouble
___ Liver Trouble
___ Hepatitis (A,B,C)
___ Colon Trouble

List Prescription & Non-Prescription drugs you take:_____

_____

_____

____

INITIAL NERVE SYSTEM PROFILE

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)*

Spinal traumas in the past? _____
Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____
Trauma as a child! i.e. fall on your head, impact to your head, concussion,
fall onto your back or tailbone, biking accident_____
Work around the house – lifting, bending, woke up with stiff neck, "back went out"

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) **Pt #_____**

Patient Name: _____ Date: _____

Please circle the number that best describes the question asked.
If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain _____ Worst possible pain
0 1 2 (3) 4 5 6 7 8 (9) 10

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1. How would you rate your pain RIGHT NOW?

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST? (How close to 0 does your pain get at its best?)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST? (How close to 10 does your pain get at its worst?)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

Score_____