



New Practice Member Application

Name _____ Age & DOB: _____ - / / SSN: _____

Address _____ City _____ State _____ Zip _____

Phone (Cell) _____ (Home) _____

Email Address _____ Occupation _____

Employer's Name _____ Single / Married / Divorced / Widowed

Spouse's Name _____ Number of Children _____

Names, Ages, & Gender _____

Who may we thank for referring you? _____

List The Health Concerns that Brought You Into This Office

Health Concern: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or Intermittent (I)?
Chief Complaint:	_____	_____	_____	_____	_____
Second:	_____	_____	_____	_____	_____
Third:	_____	_____	_____	_____	_____
Fourth:	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? Yes No

If Yes: Chiropractor Medical Doctor Other _____

Who? _____ When? _____ Results? _____

Please mark "P" For In The **Past** OR Mark "C" for **Currently** Have:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Jaw/TMJ Pain | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Tight/Sore Muscles |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Arthritis/Joint Pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Nausea | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numb/Tingling in Arms |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Numb/Tingling in Legs/Feet |
| <input type="checkbox"/> Hip/Leg Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Spinal Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures | Other: _____ | |

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

List all over the counter & prescription medications you are on, & the reason for each: (May use back of this page)

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? Yes No Fractured a Bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____

Social History

- 1. Smoking: How often? Daily Weekends Occasionally Never
- 2. Alcohol: How often? Daily Weekends Occasionally Never
- 3. Exercise: How often? Daily Weekends Occasionally Never
- 4. Have you consumed any caffeine or caffeine products within the past 48 hours? Yes No

Quadruple Visual Analogue Scale

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.

(For reference, 0 = no pain and 10 = worst possible pain.)

1. How would you rate your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE 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?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

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

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Activities of Life

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

<u>ACTIVITY</u>	<u>EFFECT</u>			
Carrying 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
Climbing 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
Driving	<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
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<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
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
Walking	<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
Concentration (Reading)	<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
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

How has your health affected your life in a negative way?

What are your health goals?

AUTHORITY CHIROPRACTIC

Family Health History

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					