

Application for Care at Chi Rho Chiropractic Health & Wellness Center

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS: Please fill out all spaces-should you have no answer please list N/A

Name: _____ Birth Date: ____-____-____ Age: _____ Male Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Social Security #: _____ Driver's License #: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Occupation: _____
Names and Ages of your children: _____
Marital Status: Single Married Divorced Separated
Name & Number of Emergency Contact: _____ Relationship: _____
Name of Previous Chiropractor: _____ How often did you see them? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office and the date that it began:

Primarily: _____ Date _____
Secondarily: _____ Date _____
Third: _____ Date _____
Fourth: _____ Date _____

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

Primary or chief complaint is a : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is a : 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 is the problem at its worst? AM PM mid-day late PM

How often do you suffer with discomfort/pain 1-2x per week 3-4x everyday occasionally

How long does it last? Constant On and off during the day

What type of pain is it? Intermittent Sharp constant dull Throbbing Numbness

What relieves your symptoms? _____

What makes them feel worse? _____

Have your Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____ What medication were you given for relief? _____

How long were you under care?: _____ What were the results? _____

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? _____

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 MARK** the areas on the Diagram with the following **letters** to describe your symptoms: **R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling**

Is your problem the result of ANY type of accident? Yes, No

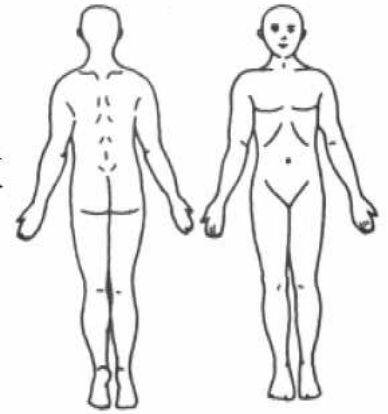
If **YES** please identify type:

Auto Work Home Other (please explain): _____

Date of Accident: ____ - ____ - ____ approx. time of day? ____am ____pm

Did you report this accident to anyone? No Yes **If yes** to whom: _____

Did you receive any type of care? Yes, No If YES by who & where _____



When was your most recent auto accident? _____

Speed on impact? _____ Front, side, **OR** rear-end collision?

Treatment received? YES NO **If yes**, by whom? _____

When was your most recent stress or strain at work? _____ Were you treated? YES NO **If yes**,

EXPLAIN: _____

Please list any other work related injuries or incidents prior to this one: _____

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: _____

Identify all hobbies/sports or recreational activities you participate in: _____

- When was your most recent stress or strain during your activity? _____
- Was any treatment received? YES / NO IF YES EXPLAIN: _____
- When was the one before that? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

CURRENT & PAST HISTORY

Please list your medication(s), what they are for and how long you have taken them (even if you have given them to us in the past)

Please list all vitamins that you take _____

How much water do you drink on a daily basis? _____

Do you suffer from any type of allergies? _____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Diabetes ___ Fracture ___ Disability ___ Cancer ___ Heart Attack ___ Osteo Arthritis ___ Cerebral Vascular ___ Rheumatoid Arthritis ___ Other serious conditions:

PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

| | HOW LONG AGO | TYPE OF CARE RECEIVED AND BY WHOM |
|--------------------|--------------|-----------------------------------|
| INJURIES | → | |
| SURGERIES | → | |
| CHILDHOOD DISEASES | → | |
| ADULT DISEASES | → | |

Reserved for doctor's use only Systems reviewed with patient: Musculoskeletal Neurological**ACTIVITIES OF LIFE**

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

| ACTIVITIES: | EFFECT: | | | |
|--------------------------|------------------------------------|---|---|--|
| 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 |
| Reading/Concentration | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Bathing | <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 |
| Shaving | <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 |
| Long periods of Sitting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Long periods of Standing | <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 |
| Walking | <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 |
| Sweeping/Vacuuuming | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dishes | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Laundry | <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 |
| Garbage | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Steps | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting Groceries | <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 |
| Sleep | <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 |
| Other: _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

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
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does you present problem affect the following:

IDENTIFY TYPE:

EFFECT:

| | | | | |
|-------|------------------------------------|---|---|--|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

FAMILY HISTORY:

Family History of Health Problems (please list type, how long, and treatment)

_____ Mother: _____

_____ Father: _____

_____ Sister(s): _____

_____ Brother(s): _____

_____ Grandmother(s): _____

_____ Grandfather(s): _____

Any other hereditary conditions the doctor should be aware of. No Yes: _____



I hereby authorize payment to be made directly to Chi Rho Chiropractic Health & Wellness Center, 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 Chi Rho Chiropractic Health & Wellness Center for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date Completed

Chi Rho Chiropractic Health & Wellness Center
 Dr. Terry Harmon
 114 East Main Street
 Morganfield, KY 42437
 270-389-9696

Patient's Name: _____

HR#: _____