ENTRANCE APPLICATION & HISTORY OF COMPLAINT
DATE_____ PATIENT ID#_____

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

(Please Print)

Name_____
First Middle Initial Last

Address_____City_____State____Zip_____

Sex: ____Female ____Male Birthdate_____Age_____ Height_____Weight_____

Driver's License No._____ State_____

Social Security No._____ E-mail_____

Home Phone(_____)_____Cell Phone(_____)_____Work Phone(_____)_____

Do you prefer to receive calls at: ____Home ____Work ____Cell ____No Preference

___Married ___Widowed ___Single ___Minor ___Separated ___Divorced

Patient Employer/School_____Occupation_____

Employer/School Address_____City_____State____Zip_____

Spouse or parent's name_____Employer_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency_____Phone(_____)_____

Name of person responsible for this account_____

Relationship to patient_____Phone(_____)_____

Have you had any surgeries: ☐ No ☐ Yes If yes, Last Surgery Date: _____

Please list all surgeries:

_____

_____

Symptoms

Please list your First Chief Complaint (only one): _____Date of onset: _____

What is the cause of your complaint? ___Auto Accident ___Work Injury ___Other Accident ___Illness

___Aggravation of a congenital condition ___Unknown

Please describe how THIS ONSET of your chief complaint started (give specific details):

_____

_____

How often is this pain experienced: ___Constant ___Frequent ___Intermittent ___Occasional

Is this condition getting progressively worse? ___No ___Yes

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning

___Tingling ___Cramps ___Stiffness ___Swelling ___Other

Rate the severity of your pain (1-mild pain/discomfort to 10-severe pain): _____

Other Complaints (if any)

***Secondary complaint:** _____

Rate the severity of your pain (1-mild/discomfort to 10-severe pain): _____

How often is this pain experienced: ___Constant ___Frequent ___Intermittent ___Occasional

Is this condition getting progressively worse? ___No ___Yes

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning

___Tingling ___Cramps ___Stiffness ___Swelling ___Other

***Third complaint:** _____

Rate the severity of your pain (1-mild/discomfort to 10-severe pain): _____

How often is this pain experienced: ___Constant ___Frequent ___Intermittent ___Occasional

Is this condition getting progressively worse? ___No ___Yes

Type of Pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning

___Tingling ___Cramps ___Stiffness ___Swelling ___Other

Present illness /Conditions:					
☐ AIDS	☐ Cirrhosis/hepatitis	☐ Gout	☐ Kidney trouble	☐ Pacemaker	☐ Stroke
☐ Allergies	☐ Concentration Loss	☐ Hay Fever	☐ Low Blood Pressure	☐ Prostate trouble	☐ Thyroid trouble
☐ Anemia	☐ Depression	☐ Headaches	☐ Lumps	☐ Rheumatic fever	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Heart Problems	☐ Masses	☐ Rheumatoid Arthritis	☐ Ulcer
☐ Asthma	☐ Dislocated Joints	☐ Hernia	☐ Mental/Emotional Difficulty	☐ Scoliosis	☐ Vertigo
☐ Bone fracture	☐ Diverticulitis	☐ Herniated Discs	☐ Migraines	☐ Seizures	
☐ Cancer	☐ Dizziness	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Spinal Disc Problems	
☐ Chills	☐ Epilepsy	☐ HIV/ARC	☐ Osteoporosis	☐ STDs	
Other:					

Family History-Please mark if your siblings, parents or grandparents have had any of the following:					
☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	☐ Stroke
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus
Other:					

Social History:			
Alcohol? ☐ No ☐ Yes Drinks per week?	Cigarettes? ☐ No ☐ Yes Packs per day?	Caffeine? ☐ No ☐ Yes Drinks per day?	Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous
What vitamins do you take?			
Interested in nutritional supplements to improve your health and/or speed your recovery? ☐ No ☐ Yes			
Interested in a structured weight management program that would not involve drugs/medication? ☐ No ☐ Yes			

Please list all medications you are currently taking: _____

Please list any allergies you may have: _____

Are you aware of any pre-existing structural pathology related to your complaints? If yes, please describe: _____

Would you like a copy of the report of findings sent to your family doctor? ___Yes ___No

If yes, what is your doctor's name and address? _____

_____

Please mark below (X) on the areas where your pain is located: