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

APPLICATION FOR CARE AT WEBER CHIROPRACTIC

Today's Date: _____

_____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Fax:_____
Mobile Phone: _____ Work Phone: _____ Fax: _____
Social Security #: _____ Driver's License #: _____
Employer: _____ Occupation: _____
Name of Spouse: _____Spouse's DOB: _____ Spouse's Employer: _____
Occupation: _____ Ages of your children: _____
_____
Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

If you have symptoms, what are they: 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 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 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

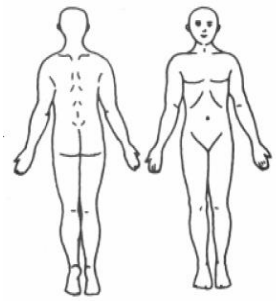
How did the injury happen?_____

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 problem the result of ANY type of accident? ☐ Yes, ☐ No

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

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.
_____ _____
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:

_____

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

FAMILY HISTORY:

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

I hereby authorize payment to be made directly to WEBER CHIROPRACTIC, 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 WEBER 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**