Network Family Wellness Centers
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ADULT NEW PATIENT APPLICATION
WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

Section 1: Patient Information

Appt. Date:_____ **Referred *By:*** _____

Name (first, middle, last):_____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth:___/ /_____Age: _____

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

Cell Phone:_____/Carrier_____Home Phone:_____Work Phone: _____

Social Security Number:_____Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employer:_____Occupation:_____Email: _____

Name of Spouse/Significant Other: _____ Name & Ages of Children: _____

Emergency Contact:_____Relationship_____Phone # (____) _____

To conserve resources, we generally utilize Email and text for regular communication.

May we communicate with you via Email? ☐ Yes ☐ No | Text ☐ Yes ☐ No Carrier:_____

1. Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office?

Friend/Family Member Name:_____

☐ Telephone Call ☐ Yellowpages ☐ Sign ☐ Website ☐ Presentation ☐ E-mail

2. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? _____ ☐ Never

For what reason were you seen?_____ Were you helped? ☐ Yes ☐ No

3. When was your last complete spinal examination including x-rays? _____ ☐ Never

4. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem? ☐ Yes ☐ No

5. NeuroSpinal Dysfunctions may cause decay and degeneration which results in grinding or cracking. Do you ever hear noise when you move your head or neck? ☐ Yes ☐ No

6. NeuroSpinal Dysfunctions can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? ☐ Yes ☐ No

7. Poor posture leds to poor health and often indicates a spinal problem. How would you rate your posture?

Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Excellent ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

8. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.

Low ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 High

9. What is your motivation to seek/ receive care in this office?

_____

10. Have you ever been diagnosed with cancer? ☐ Yes ☐ No If so, what kind?_____Year Diagnosed: _____

11. Have you ever had spinal surgery? ☐ Yes ☐ No If yes, where:_____

13. Spinal health is especially important during pregnancy. Is there any chance that you are pregnant? ☐ Yes ☐ No

14. What activities would you like to do that your health is impairing you from doing?

_____

15. How would your life change if you had optimal health? _____

_____

16. What needs to happen in order for you to have optimal health and healing? _____

_____

17. If the doctor feels that you will benefit from chiropractic care, are you willing to follow his/her recommendations?

☐ Yes ☐ No

18. Are you Medicare eligible? ☐ Yes ☐ No

19. If under 25: Are you or your parents financially responsible for your health care? _____

Section 2: History of Concern

Primary Concern(s): _____

Secondary Concern(s): _____

Tertiary Concern(s): _____

Auto and work-related injuries can cause serious spinal problems. Are your complaints due to an Accident? ☐ YES ☐ NO

If yes, what type? ☐Work ☐Auto ☐ Personal Date of Accident_____If Work or Auto accident, have you reported this accident to anyone? ☐ Yes ☐ No Who was it reported to? _____

Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen. _____

_____

Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. What medications are you currently taking? (Prescription and non-prescription)

_____

_____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? ❑ No ❑ Yes

If yes whom & what condition(s): _____

_____

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Patient/Guardian's Signature:_____Date:_/_____/_____

Doctor's Signature_____ Date Form Reviewed:_/_____/_____

Patient Name _____ **DOB:**_____

Section 4: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause* ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-2007 ***Type of Collision:*** **Front end** **10 mph** ***Injuries:*** **Neck Whiplash/Neck on Rt. side**

Date:___/ /_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries: _____ ☐Lt ☐Rt

Date:___/ /_____ Type of Collision: ☐ Front ☐ Side ☐ Rear Speed_____ Injuries:_____ ☐Lt ☐Rt

B. Sports Injuries (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: 1-1-2008 ***Type of Sport:*** **Basketball** ***Type of Injury:*** **Sprained Right Knee**

Date:___/ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

Date:___/ /_____ Type of Sport_____ Type of Injury: _____ ☐ Lt☐Rt

C. Slips, falls, & Bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 2-1-2008 ***Type of Injury:*** **Slipped on ice & bruised Left Elbow**

Date:___/ /_____ Type of Injury:_____ ☐ Lt☐Rt

Date:___/ /_____ Type of Injury:_____ ☐ Lt☐Rt

D. Repetitive Injuries (Please list **all** repetitive injuries you've had in the past.)

Example: 3-1-2008 ***Type of Injury:*** **Lifting boxes injured lower back**

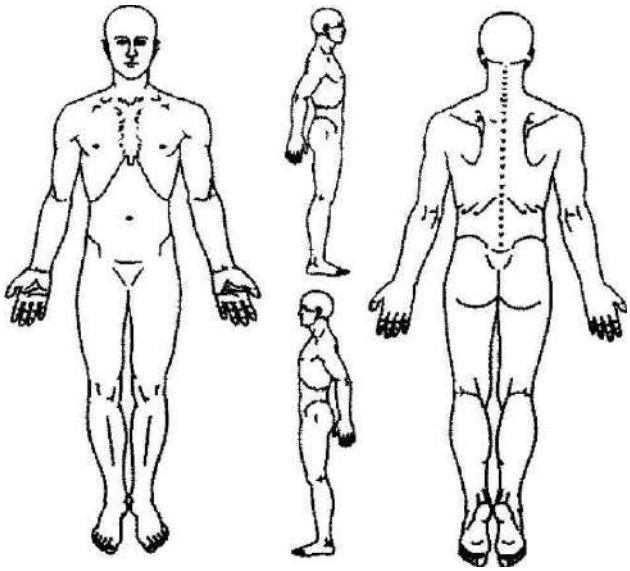
Date:___/ /_____ Type of Injury:_____ ☐ Lt☐Rt

Date:___/ /_____ Type of Injury:_____ ☐ Lt☐Rt

Exam

***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



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Doctor's Signature_____ Date Form Reviewed:_/_____/_____

Patient Name _____ **DOB:**_____

Section 5: Present and Past Conditions

Using the codes listed below, please fill in ***EVERY*** blank with the applicable letter.

Check to indicate if you have Pain or Stiffness and on which side of your body.

If ***both*** sides apply, please check ***R & L*** .

P = **P**ast Health Issue **C** = **C**urrent Health Issue **N** = **N**ever had this Health Condition

Example: C Shoulder ☑ Pain ☐ Stiff ☑ R ☐ L

Extremities			Location	Respiratory	Other Conditions	Male
___Hip	☐ Pain	☐ Stiff	☐ R ☐ L	___Asthma	___Headaches / Migraines	___Impotence
___Knee	☐ Pain	☐ Stiff	☐ R ☐ L	___Chest Pain	___Trouble Sleeping	___Prostate Problems
___Foot	☐ Pain	☐ Stiff	☐ R ☐ L	___Difficulty Breathing	___Excessive Sweating	**Female**
___Shoulder	☐ Pain	☐ Stiff	☐ R ☐ L	___Lung Problems	___Cancer & Type: _____	___Menopausal Problem
___Elbow	☐ Pain	☐ Stiff	☐ R ☐ L	___COPD	___Emotional / Mental Disorders	___Menstrual Cycle Problems
				Digestion	___Learning Disability	
___Wrist	☐ Pain	☐ Stiff	☐ R ☐ L	___Heartburn	___Nervous / Irritable	
___Jaw Pain	☐ Click	☐ Pop	☐ R ☐ L	___Digestion Problems	___Loss of Memory	**Social History**
___Swollen or Painful Joints				___Gallbladder Problems	___Dizziness / Loss of Balance	___Smoking How much _____ How Often _____
Spine				___Colon Trouble	___Arthritis	
___Head / Shoulders Feel Heavy / Tired				___Diarrhea / Constipation	___Epilepsy / Convulsions	___Alcoholic Beverage Consumption Occurs_____
___Neck	☐ Pain	☐ Stiff	☐ R ☐ L	___Hemorrhoids	___Knocked Unconscious	
___Upper Back	☐ Pain	☐ Stiff	☐ R ☐ L	**Immune System**	___Frequent Ear Infections	___Recreational Drugs What Used_____ How Often_____
___Mid Back	☐ Pain	☐ Stiff	☐ R ☐ L	___Skin Problems	___Ringing in Ear R / L	
___Low Back	☐ Pain	☐ Stiff	☐ R ☐ L	___Sinus Problems/ Allergies	___Hearing Loss R / L	___Exercise Type_____ How Often_____
___Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain:_____				___Frequent Colds / Flu	___Trouble Concentrating	
				___Anemia	___AIDS / HIV	
Other:_____				___Other: _____	___Fracture / Dislocation of Bones: _____	
				Organ Problems or Dysfunction	_Other: _____	
Numbness / Tingling or Pain In:				___Diabetes	**Urinary Tract**	
___Arm			☐ R ☐ L	___Liver Trouble	___Kidney Trouble	
___Hand /Fingers			☐ R ☐ L	___Hepatitis	___Frequent Urination	
___Legs			☐ R ☐ L	___High/Low Blood Pressure	___Bedwetting	
___Foot / Toes			☐ R ☐ L	___Heart	___Other:_____	

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Section 6: Past Health Conditions

Transfer conditions from page 3 marked with a "P" for past health issue.

Please list: ***when, how long it lasted, description of symptoms (ex. Sharp, pain, burning), how often (ex. Weekly, daily), severity (0=no pain; 10=worst pain)*** **.**

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Past Health Issue: _____

_____

Are any of these past conditions due to an accident? ☐ YES ☐ NO If yes, what type? ☐ Work ☐ Auto ☐ Personal

Date of Accident_ _ Have you seen any doctors for this condition: ☐ YES ☐ NO

Please list the doctor specialty, & for how long you were seen._____

List any past hospitalizations and/or surgeries:

Surgeries: _____

List Hospitalizations Other Than Surgeries: _____

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