

# Application for Care at SpineGeek Chiropractic

Today's Date: \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status:  Single  Married  Widowed Do you have Insurance:  Yes  No

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

## HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_ 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 **circling the number**:

**Primary** or chief complaint is : 0 1 2 3 4 5 6 7 8 9 10

**Second** complaints is : 0 1 2 3 4 5 6 7 8 9 10

**Third** complaint is : 0 1 2 3 4 5 6 7 8 9 10

**Fourth** complaint is : 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  Mid-Day  PM

How long does it last?  Constantly  Off and On  It comes and goes throughout the week

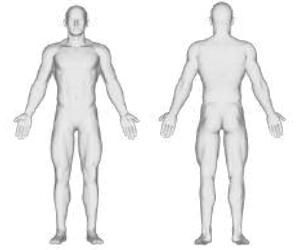
How did the injury happen? \_\_\_\_\_

Has this 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(s): \_\_\_\_\_

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**\*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

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 or **N** for Never have had:

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

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**PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to 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

## 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 this office 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 this office for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Name

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

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## Activities of Daily Living/Symptoms/Medications

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

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

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<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
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<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
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to 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

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Please mark **P** for in the Past, **C** for Currently have and **N** for Never

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant               | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems     | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Digestive Problems   |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Colon Trouble         | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Menopausal Problems   | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menstrual Problem     | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> PMS                   | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Learning Disability   | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Trouble Sleeping      | <input type="checkbox"/> Hepatitis (A, B, C)  |
| <input type="checkbox"/> Impotence/Sexual Dysfunction       |   | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Ulcers                | <input type="checkbox"/> Legs and Feet        |

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

\_\_\_\_\_

Dr. Arvay's office communicates office closures, appointment reminders and event notices via text message and email. Please advise which cell phone number and email would be best for these communications. This will enable us to serve you better.

Cell Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Full Name: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Normal texting/data charges as imposed by your carrier will apply.

JDD, DC 5/2011



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FOR OFFICE USE ONLY.

Perfect Patients  Emails  Refersion

Staff Signature \_\_\_\_\_