



ADULT PRACTICE MEMBER FORM

AUTHORITY CHIROPRACTIC

OFFICE USE ONLY

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ABR Y/N

PERSONAL INFORMATION

Full Name : _____ Gender: Male Female

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

Date of Birth : _____ Age: _____ Last 4 SSN: _____ Marital Status: Single Married Widowed Divorced

Email : _____ Cell Phone: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Number of Children: _____

Names & Ages of Children: _____

Who may we thank for referring you? _____

CURRENT HEALTH

What major health concerns bring you into our office? _____

When did the condition(s) first begin? _____

Have you received care for this problem before? Yes No - If yes, when? _____

If Yes: Chiropractor Medical Doctor Other: _____

If Yes: Who? _____ Results? _____

How did the problem(s) start? Suddenly Gradually Post-Injury

This condition is: Getting Worse Improving Intermittent Constant Unsure

What makes the problem better? _____

What makes it worse? _____

Past
Current

- Headaches
- Migraines
- Jaw/TMJ Pain
- Neck Pain
- Shoulder Pain
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Lower Back Pain
- Hip/Leg Pain
- Knee Pain
- Foot Pain
- Tight/Sore Muscles
- Ear Infections
- Hearing Loss
- Ringing in the Ears

Past
Current

- Dizziness
- Loss of Balance
- Allergies
- Sinus Issues
- Frequent Colds
- Asthma
- Stress
- Anxiety
- Depression
- ADD/ADHD
- Double/Blurry Vision
- Thyroid Issues
- Loss of Energy
- Heart Problems
- Nausea
- Digestive Issues

Past
Current

- GERD/Gastric Reflux
- Diarrhea
- Constipation
- Bed Wetting
- Bladder Problems
- Pregnant
- Infertility
- Menstrual Problems
- Prostate Problems
- Sexual Dysfunction
- Diabetes
- Stroke
- Arthritis
- Fibromyalgia
- Chest Pain

Past
Current

- Difficulty Breathing
- Tremors
- Constipation
- Seizures
- Cancer
- Sleep Problems
- Sports Injury
- High Blood Pressure
- Numb/Tingling in Arms
- Numb/Tingling in Legs/Feet
- Skin Problems
- Sciatica
- Scoliosis
- Poor Posture
- Spinal Surgery

Other: _____

List all surgical operations & years: _____

List all over the counter & prescription medications you are on, & the reason for each: (May use back of this page) _____

Other trauma: _____

List any other injuries to your spine, minor or major, that the doctor should know about: _____

Have you ever been in an auto accident? List all: _____

Do you have an open auto accident claim? Yes No

Have you ever been knocked unconscious? Yes No Fractured a bone? Yes No

If yes to either of the above, please describe: _____

Are you military or first responder? (Active or Retired) _____

Did you receive the COVID-19 injection? Yes No

SOCIAL HISTORY

Smoking: How often? Daily Weekends Occasionally Never

Alcohol: How often? Daily Weekends Occasionally Never

Exercise: How often? Daily Weekends Occasionally Never

Have you consumed any caffeine or caffeine products within the past 48 hours? Yes No

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

How would you rate your pain right now?



What is your typical or AVERAGE pain?



What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____ %

What is your pain level at its WORST (How close to 10 does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst? _____ %

ACTIVITIES OF LIFE

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

- | | | | | |
|-----------------------------|---------------------------------|--|--|---|
| Carrying Groceries | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Sit to Stand | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Climbing Stairs | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Pet Care | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Driving | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Extended Computer Use | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Household Chores | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Lifting Children | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Dressing | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Washing/Bathing | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Sexual Activities | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Sleep | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Sitting | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Standing | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Walking | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Yard Work | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Other: <input type="text"/> | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |
| Other: <input type="text"/> | <input type="radio"/> No Effect | <input type="radio"/> Painful (can do) | <input type="radio"/> Painful (limits) | <input type="radio"/> Unable to Perform |

How has your health affected your life in a negative way?

If your body was functioning and adapting better, what are 2 things you would be able to do?

FAMILY HEALTH HISTORY

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					