# 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 |
| ☐ | ☐ | 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 | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sit to Stand | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Climbing Stairs | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Pet Care | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Driving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Extended Computer Use | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Household Chores | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Lifting Children | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Dressing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Washing/Bathing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sexual Activities | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sleep | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sitting | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Standing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Walking | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Yard Work | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Other: | | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Other: | | ○ Painful (can do) | ○ Painful (limits) | ○ 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 | | | | | |