T
CD
E
C

ID# Y / N

Ins

PDR

AUTHORITY CHIROPRACTIC

New Practice Member Application

Name_____Age & DOB:____-____/____/_____SSN:_____

Address_____City_____State_____Zip_____

Phone (Cell)_____ (Home)_____

Email Address_____Occupation_____

Employer's Name_____Single / Married / Divorced / Widowed

Spouse's Name_____Number of Children_____

Names, Ages, & Gender_____

Who may we thank for referring you?_____

List The Health Concerns that Brought You Into This Office

Health Concern: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or Intermittent (I)?
Chief Complaint:	_____	_____	_____	_____	_____
Second:	_____	_____	_____	_____	_____
Third:	_____	_____	_____	_____	_____
Fourth:	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? ☐ Yes ☐No

If Yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other_____

Who?_____ When?_____ Results?_____

>>>>>Below: Please mark **"P"** For In The **Past** OR Mark **"C"** for **Currently** Have:<<<<<

__Headaches	__Ear Infections	__Sinus Issues	__Kidney Problems	__Sexual Dysfunction
__Migraines	__Hearing Loss	__Frequent Colds	__Bladder Problems	__Sleep Problems
__Jaw/TMJ Pain	__Ringing in the Ears	__Thyroid Issues	__Menstrual Problems	__Tight/Sore Muscles
__Neck Pain	__Dizziness	__Asthma	__Prostate Problems	__Sports Injury
__Shoulder Pain	__Loss of Energy	__Chest Pain	__Infertility	__Sciatica
__Arm Pain	__Nervousness	__Heart Problems	__Fibromyalgia	__Arthritis/Joint Pain
__Upper Back Pain	__Double/Blurry Vision	__Nausea	__Epilepsy/Convulsions	__GERD/Gastric Reflux
__Mid Back Pain	__Anxiety	__Ulcers	__Tremors	__Numb/Tingling in Arms
__Lower Back Pain	__ADD/ADHD	__Digestive Issues	__Disc Problems	__Numb/Tingling in Legs/Feet
__Hip/Leg Pain	__Loss of Balance	__Diarrhea	__Scoliosis	__Stomach Problems
__Knee Pain	__Depression	__Constipation	__Poor Posture	__High/Low Blood Pressure
__Foot Pain	__Allergies	__Bed Wetting	__Skin Problems	__Difficulty Breathing
__Pregnant	__Stroke	__Cancer	__Heart Attack	__Spinal Surgery
__Diabetes	__Arthritis	__Seizures	Other:_____	

List all surgical operations & years:_____

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

_____

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

_____

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

Have you ever been knocked unconscious? ☐Yes ☐No Fractured a Bone? ☐Yes ☐No

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

Other trauma: _____

Social History

1. Smoking: How often? ☐Daily ☐Weekends ☐Occasionally ☐Never
2. Alcohol: How often? ☐Daily ☐Weekends ☐Occasionally ☐Never
3. Exercise: How often? ☐Daily ☐Weekends ☐Occasionally ☐Never
4. 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.

(For reference, 0 = no pain and 10 = worst possible pain.)

1. How would you rate your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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

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

0 1 2 3 4 5 6 7 8 9 10

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

Practice Member Name: _____ Date:_____

Activities of Life

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

ACTIVITY	EFFECT			
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
Static Sitting	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Static 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
Concentration (Reading)	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Other:_____	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Other:_____	☐No Effect	☐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?

_____

_____

_____

AUTHORITY
CHIROPRACTIC

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					