Application for Care at Blau Family Chiropractic and Integrated Wellness

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Preferred Language: _____Race: _____Ethnicity: _____

Whom may we thank for referring you to this office? _____

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 complaint 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

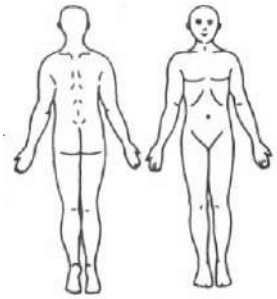
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen? _____

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: _____ ☐ **N/A**



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
What relieves your symptoms? _____

What makes your symptoms feel worse? _____

What do you have difficulty performing in reference to the specific complaint selected above?

☐ Bending Over	☐ Exercising	☐ Looking over Shoulder	☐ Sitting
☐ Caring for Family	☐ Getting in/out of Car	☐ Making Love	☐ Standing
☐ Climbing Stairs	☐ Getting to Sleep	☐ Lying Down	☐ Staying Asleep
☐ Concentrating	☐ Grocery Shopping	☐ Reaching Overhead	☐ Using Computer
☐ Dressing Self	☐ Household Chores	☐ Rising out of chair/bed	☐ Walking
☐ Driving Car	☐ Lifting Objects	☐ Showering or Bathing	☐ Yard Work

Is your problem the result of **ANY** type of accident? ☐ Yes, ☐ No Please Circle: Worker's Compensation / Personal Injury / Auto Accident

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 check ☐ ALL symptoms you have ever had, even if they do not seem related to your current problems

☐Arthritis
☐Back Curvature
☐Mental / Emotional Disorders
☐Diabetes
☐Swollen or Painful Joints
☐Skin Problems
☐Bruise easily
☐Cancer
☐Allergies
☐Frequent Colds
☐Upper Back Pain / Stiffness
☐Excessive Gas
☐Constipation
☐Diarrhea
☐Impotence
☐Kidney Problems
☐Frequent Urination
☐ Menstrual Problems / PMS
☐ Menopausal problems
☐ Convulsions / Epilepsy

☐Headache
☐Migraine Headache
☐Neck Pain R/L
☐Shoulder Pain R/L
☐Numbness or Tingling
☐Carpal Tunnel Syndrome
☐Dizziness
☐Ringing in Ears
☐Hearing Loss
☐Loss of Balance
☐Digestive Problems
☐Depression
☐Attention Disorder
☐Anxiety Disorder
☐Eating Disorder
☐Trouble concentrating
☐Loss of memory
☐Ear Infection
☐Learning Disability
☐Prostate Problems

☐Asthma
☐Chest Pain
☐Difficult Breathing
☐Heart Problems
☐Heart Attack
☐High Blood Pressure
☐Low Blood Pressure
☐Varicose Veins
☐Liver Trouble
☐Gall Bladder Trouble
☐Mid Back Pain / Stiffness
☐Pain with cough, or strain
☐Hip Pain
☐Low Back Pain / Stiffness
☐Sciatica
☐Stroke
☐Muscle Tightness
☐Trouble sleeping
☐Surgeries _____
_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPPA policy at the front desk. Please initial here to indicate you have been made aware of its availability: _____*The statements made on this form and accurate and true to the best of my recollection and I agree to allow this office to examine me for further evaluation. By signing this form you are waiving receipt of a clinical summary after every visit. You have the right to request a copy of your notes at any time.*

_____

I hereby authorize payment to be made directly to Blau Family Chiropractic and Integrated Wellness, 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 Blau Family Chiropractic and Integrated Wellness for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**