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

APPLICATION FOR CARE AT MAX HEALTH CHIROPRACTIC

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

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

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

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Last four digits of Social Security #: _____

Employer: _____ Occupation: _____

Marital Status: ❑ Single ❑ Married Spouse's Name _____ Number of Children:_____

Name & Number of Emergency Contact: _____ _____Relationship: _____

Do you have Insurance: ❑ Yes ❑ No Insurance Company:_____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ 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 c***ircling 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: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 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

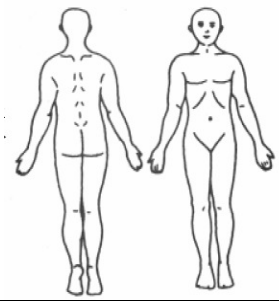
How did the injury happen?_____

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 them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No (If yes, see the front desk for additional information)

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 or experienced any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had*:

___ Broken Bone	___Dislocations	___ Tumors	___Rheumatoid Arthritis	___ Fracture
___Disability	___ Heart Attack	___Osteo Arthritis	___ Diabetes	___Cerebral Vascular
___ Ulcers	___ Heart Problem	___ Headache	___ Pregnant (Now)	___ Dizziness
___ Prostate Problems	___ Cancer	___ High Blood Pressure	___ Neck Pain	___ Frequent Colds/Flu
___ Heartburn	___ Impotence	___ Loss of Balance	___ Jaw Pain, TMJ	___Convulsions/Epilepsy
___ Fainting	___ Digestive Problems	___ Shoulder Pain	___ Tremors	___ Double Vision
___ Colon Trouble	___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea
___ Constipation	___ Low Blood Pressure	___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears
___ Menopausal Problems	___ Asthma	___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss
___ Menstrual Problem	___ Difficulty Breathing	___ Hip Pain	___ Sinus/Drainage Problem	___ Depression
___ PMS	___ Lung Problems	___ Back Curvature	___ Swollen/Painful Joints	___ Irritable Bowel
___ Bed Wetting	___ Kidney Trouble	___ Scoliosis	___ Skin Problems	___ Mood Changes
___ Learning Disability	___ Gall Bladder Trouble	___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling arms, hands, fingers		___ Numb/Tingling legs, feet, toes		___ Allergies
___ Trouble Sleeping	___ Hepatitis (A,B,C)	___ Other Serious Condition:_____		

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 →			

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: _____

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug Use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Prescription Medication Use:

Type	Name	Frequency
▪ **Nerve Pills**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Pain Killers**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Anti-Depressants**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Muscle Relaxers**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Blood Pressure**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Cholesterol**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Blood Thinners**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Mood Stabilizers**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Estrogen Therapy**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Insulin**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **NSAIDS** (Aspirin, Ibuprofen)	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
▪ **Other**	_____	❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

5. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following Daily Activities (Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life)

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ 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
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

AUTHORIZATION FOR SERVICES

I hereby authorize payment to be made directly to Max Health Chiropractic, 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 Max Health Chiropractic for any and all services I receive at this office.

_____ _____ / _____ /_____
Patient or Authorized Person's Signature Date

The Nature of Chiropractic Treatment: The doctor will use his/her hands or mechanical device in order to move your joints. You may feel a "click" or a "pop" similar to noise produced when a knuckle is "cracked," and you may feel movement of the joint.
Possible Risks: Like all forms of health care, chiropractic holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare," and statistically less of then than the complications from taking a single aspirin tablet.
Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.
Treatment objectives as well as the risks associated with chiropractic adjustments, and all other procedures provided at Max Health Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____**(***Witness Initials)*
Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies (Females Only)
☐ The first day of my last menstrual cycle was on ____-____-____ (Date)
☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.
By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ _____(*Witness Initials*)
Patient or Authorized person's Signature Date

RESERVED FOR DOCTOR'S USE

Systems Reviewed with Patient: ❑ Musculoskeletal ❑ Neurological

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

JDD,DC 5/2011