**Application for Care at Rock Springs Family Chiropractic**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: 🞏 Single 🞏 Married Do you have Insurance: 🞏 Yes 🞏 No Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Who can we thank for referring you to our office?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY OF PHYSICAL COMPLAINT**

Please identify the condition(s) that brought you to this office:

 Primary Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third Complaint: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the number that best describes the question being asked. If you have more than one complaint/condition above, indicate the score for each one using the shapes provided. **See example below:**

*(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)*

***EXAMPLE:*** *Headache Neck Pain Low Back Pain*

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

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 is your pain level AT ITS WORST (How close to “10” does your pain get at it’s worst)?

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 🞏 I experience it on and off during the day 🞏 It comes and goes throughout the week*

How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your problem a result of ANY type of accident *( YES or NO )*

Have you been treated for this in the past? *🞏No 🞏 Yes* **If yes,** when: \_\_\_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care: \_\_\_\_\_\_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(🞏 I’ve never been to a chiropractor)*

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**DAILY ACTIVITIES: Effects of Current Conditions On Performance**

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 |
| Recreation Activities  | [ ]  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 |
| 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 |

**INITIAL NERVE SYSTEM PROFILE**

When was your most recent auto accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What speed was the collision? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your most recent strain / stress at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the manner of the injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was treatment received? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job require you remain in long term stressful postures?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past:

- Collision, quick burst, or repetitive motion sports (football, wrestling, basketball, baseball, soccer, tennis, golf, track/field)?

*( YES or No ) Please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Trauma as a child? (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident)?

*( YES or No ) Please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Work around the house – lifting, bending, woke up with stiff neck, “back went out”?

*( YES or No ) Please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Any other traumas not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

 **Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ Headache \_\_\_ Pregnant (Now) \_\_\_ Dizziness \_\_\_ Prostate Problems \_\_\_ Ulcers

\_\_\_ Neck Pain \_\_\_ Frequent Colds/Flu \_\_\_ Loss of Balance \_\_\_ Impotence/Sexual Dysfun. \_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ \_\_\_ Convulsions/Epilepsy \_\_\_ Fainting \_\_\_ Digestive Problems \_\_\_ Heart Problem

\_\_\_ Shoulder Pain \_\_\_ Tremors \_\_\_ Double Vision \_\_\_ Colon Trouble \_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain \_\_\_ Chest Pain \_\_\_ Blurred Vision \_\_\_ Diarrhea/Constipation \_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain \_\_\_ Pain w/Cough/Sneeze \_\_\_ Ringing in Ears \_\_\_ Menopausal Problems \_\_\_ High Cholesterol/Triglycerides

\_\_\_ 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 \_\_\_ Asthma \_\_\_ Kidney Trouble

\_\_\_ Scoliosis \_\_\_ Skin Problems \_\_\_ Mood Changes \_\_\_ Learning Disability \_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers \_\_\_ ADD/ADHD \_\_\_ Eating Disorder \_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes \_\_\_ Allergies \_\_\_ Trouble Sleeping \_\_\_ Hepatitis (A,B,C)

**\_\_\_** Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis \_\_\_Fracture

\_\_\_ Heart Attack \_\_\_Osteo Arthritis \_\_\_ Cerebral Vascular **\_\_\_** Disability **\_\_\_** Diabetes (Prediabetes)

\_\_\_Cancer (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) **\_\_\_** Other conditions/diagnoses not listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Prescription & Non-Prescription drugs or supplements you take**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment to be made directly to Rock Springs Family 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 Rock Springs Family Chiropractic or any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

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

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

 **Doctor’s Signature Date Form Reviewed**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**INITIAL NUTRITIONAL PROFILE**

Do you eat breakfast daily from Monday to Friday? *YES or NO*

How many days per week do you skip one meal? *(0) (1) (2) (3) (4+)*

How many fast food, refined foods, or pre-pared meals do you eat per week? *(0) (1-3) (4-6) (7+)*

How many servings of fruit do you have on a given day? *(0-1) (2-3) (4+)*

How many servings of vegetables do you have on a given day? *(0-1) (2-3) (4-5)*

Do you regularly drink (1 or more per day) any of the following? *(circle all that apply)*

 Diet Soda Coffee Juice Milk Soda Alcohol

**INITIAL FITNESS PROFILE**

How many times per week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiovascular \_\_\_Hours \_\_\_Days/Wk Weight Training \_\_\_Hours \_\_\_Days/Wk

Low Impact (Yoga, etc.) \_\_\_Hours \_\_\_Days/Wk

What is your target weight? \_\_\_\_\_\_\_\_\_\_\_\_\_What is your current weight? \_\_\_\_\_\_\_\_\_\_\_

**INITIAL TOXICITY PROFILE**

Are you regularly exposed to cleaning products or industrial chemicals? *YES or NO*

Have you ever noticed mold growing in your home or your place of work? *YES or NO*

Does your home, work, school, or car have damp or mildew smell? *YES or NO*

Have you received a full standard profile of vaccinations? *YES or NO*

Do you receive yearly flu shots? *YES or NO* How many flu shots have you received? \_\_\_\_\_ (estimate)

Have you been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? *YES or NO*

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? *YES or NO*

**INITIAL STRESS PROFILE**

Do you average less than 7 hours of sleep per night? *YES or NO*

Do you ever take pills to go to sleep or relax? *YES or NO*

Do you often feel short on time and procrastinate on projects? *YES or NO*

Do you experience feelings of anxiety about completing tasks? *YES or NO*

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? *YES or NO*

Do you rely more on your memory than a planner and action list to get things done? *YES or NO*

Do you take time to pray, meditate, or visualize on a regular basis? *YES or NO*

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10) \_\_\_\_\_\_\_\_***

**Looking out 6-12 months, what would your ultimate health goal be??** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*We are here to help you reach your God-given potential, in Health and in Life!! We look forward to helping you reach your health goals!*