Integrative Chiropractic
and Wellness

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR HEALTH.
SO WE MAY BETTER SERVE YOU, PLEASE FILL OUT THE PERSONAL INFORMATION BELOW.
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK TEAM MEMBER. THANK YOU!

First Name _____ Middle _____ Last _____

Gender ❑ Male ❑ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number ___ - ___ - ____ E-mail Address _____

Birthdate _____ Age _____ Marital Status S M W D

Job Title _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Social Security Number ___ - ___ - ____

Person responsible for this account _____

Name of person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children–Names & Ages _____

_____

In case of emergency, whom should we contact? _____

Phone/Relation to Patient _____

FAMILY PHYSICIAN: _____

May we send your Family Physician updates on your progress? ❑ Yes ❑ No

What is your primary complaint? _____

_____

IS THIS WORKER'S COMPENSATION? _____ IS THIS PERSONAL INJURY? _____

(Office use only)	Account Number	Date

Integrative Chiropractic
and Wellness

NAME: **DATE:** / / **Account#:**

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? _____

_____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: _____

_____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM? _____

How did you hear about us? _____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE: / / Account#:**

SECONDARY COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location _____ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

_____

_____

2. What do you enjoy doing most in your life?

_____

_____

NOTES / COMMENTS:

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: **DATE:** / / **Account#:**

Please place a checkmark by the condition that applies to you: **P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family
Family History Key: F = Father • **M** = Mother • **B** = Brother • **S** = Sister • **GF** = Grandfather • **GM** = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

List any allergies: _____

_____

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

❑ Allergic / Immunologic
❑ Constitutional
❑ Endocrine
❑ Gastrointestinal
❑ Genitourinary
❑ Integumentary
❑ Neurological
❑ Respiratory
❑ Cardiovascular
❑ Ears / Nose / Mouth
❑ Eyes
❑ All other system reviews negative
❑ Hematological / Lymphatic
❑ Musculoskeletal
❑ Psychiatric

Notes / Comments: _____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____

NAME: _____ **DATE:** ____/____/____ **Account#:** _____

PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____

3. _____ Year_____ 4. _____ Year_____

5. _____ Year_____ 6. _____ Year_____

List any other key slips, falls or accidents you've had from childhood to present:		**Date**
1)		
2)		
3)		
4)		
5)		
What medications are you currently taking? (Include Date)		
1)	4)	
2)	5)	
3)	6)	

Have you ever taken:	**YES**	**NO**	**YEAR**
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Known allergies to medications:

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: _____

_____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: _____

_____

_____

_____

_____

_____

_____

Doctor Signature: _____

Patient Signature: _____