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

# APPLICATION FOR CARE AT GILES CHIROPRACTIC

Today's Date: _____

## PATIENT DEMOGRAPHICS

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

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

E-mail Address: _____ Mobile Phone:_____ ☐ Verizon ☐ AT&T ☐ Sprint ☐ T Mobile

Home Phone: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Children & ages: _____

Health Insurance Carrier: _____

## HISTORY of COMPLAINT

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms and/or complaints, please list in order of severity. Then rate the problem on a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain.

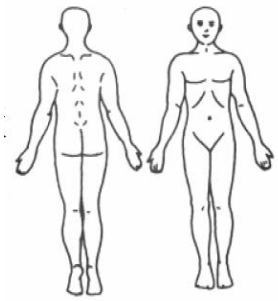
1. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
2. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
3. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
4. _____ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ Has the problem been getting ☐ better ☐ worse ☐ staying same ☐ other

How did the injury happen? _____

Are your injuries the result of an auto accident or work injury? _____ If yes, what is the date of injury? _____

**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 your symptoms feel worse? _____

**Current Medications:**

Please check all the medications (over the counter and / or prescribed) you are currently taking:

☐ Aspirin / Tylenol ☐ Pain killers ☐ Muscle relaxers ☐ Insulin ☐ Birth Control Pills ☐ Sleeping pills

☐ Anti Depressants ☐ Other: _____

_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

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? _____

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 with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

**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: _____

I hereby authorize payment to be made directly to Giles 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 Giles Chiropractic for 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: _____ HR#: _____ 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:

| ACTIVITIES: | EFFECT: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climb Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lift Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Read/Concentrate | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Getting Dressed | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Shaving | ☐ 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 |
| Yard work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Washing/Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

**Please list any changes to your Health History (i.e Falls, Prescription Changes, Vitamins, Workouts, etc):**

_____

_____

_____

**Patient signature: _____ Today's Date: __/__/__**