Adult Application for Care

RESTORE FAMILY CHIROPRACTIC

Are you over 18? ◯ Y ◯ N

Is this appointment alone or with a family member?

◯ Family Member (same day) ◯ Family Member (different day) ◯ Alone

Confidential Personal Information

First Name: _____ **Last Name:** _____ **Date Of Birth:** _____ **Biological Sex:** ◯ M ◯ F

Cell: _____ **Other Phone:** _____ **Email:** _____ **Preferred Contact Method:** ◯ Text me ◯ Call me

Street Address _____ **City** _____ **State** _____ **Zip** _____

Occupation _____ **Employer** _____ **I spend most of my time at work:** ◯ Sitting ◯ Standing ◯ Stressed ◯ Manual Labor ◯ Repetitive motion

Marital Status

◯ Single ◯ Engaged ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Name of Spouse: _____

How did you hear about us?

◯ Referral from Current Patient ◯ Google search ◯ Facebook/Instagram ◯ I saw your sign ◯ I saw you at an event ◯ Other: _____

Who can we thank for referring you? _____

Emergency Contact:

First Name: _____ **Last Name:** _____ **Phone:** _____ **Relationship:** _____

Previous Treatment

Have you ever seen a chiropractor before: ◯ Yes ◯ No

If yes, where? _____

When was your last visit? _____

Did they take Xrays? ◯ Yes ◯ No

How often were you adjusted? ◯ 2-3x/week ◯ Weekly ◯ Monthly ◯ Only when it hurt

Have you sought treatment elsewhere for this condition? ◯ Yes ◯ No

If yes, where? _____

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Please mark your PRIMARY complaint on this diagram using the following Guide:

What Brings You In Today:

_____

_____

If you are already experiencing a symptom, what is it in 3-5 words?

_____

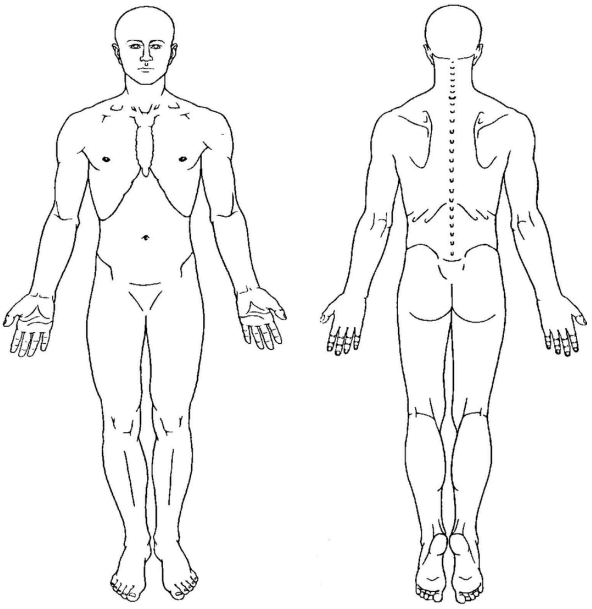
B: Burning

R: Radiating

A: Aching/Stiff

N: Numb

S: Stabbing



When did you first notice it? _____

Why did you decide to get it checked? Why now? _____

How did this problems start? ◯ Suddenly ◯ Gradually ◯ post-injury

How often do you Feel it? ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittenty

How Severe is it? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Is this condition: ◯ Getting worse ◯ Getting Better ◯ Neither better nor worse ◯ Intermittent

What makes it better? _____

What makes it worse? _____

Do you have a SECONDARY complaint? What is it in 3-5 words? _____

When did you first notice it? _____

Why did you decide to get it checked? Why now? _____

How did this problems start? ◯ Suddenly ◯ Gradually ◯ post-injury

How often do you Feel it? ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Intermittenty

How Severe is it? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Is this condition: ◯ Getting worse ◯ Getting Better ◯ Neither better nor worse ◯ Intermittent

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Symptom Review

Please check the corresponding boxes for each symptom you have experienced, both past and present:

	Past	Present		Past	Present
Concussions	☐	☐	Swollen/Painful Joints	☐	☐
Headaches/Migraines	☐	☐	Dizziness	☐	☐
Neck Pain	☐	☐	Double vision/blurred vision	☐	☐
Jaw Pain	☐	☐	Hearing loss/ear pain	☐	☐
Shoulder Pain	☐	☐	Irritability/depression	☐	☐
Upper Back Pain	☐	☐	ADD/ADHD	☐	☐
Low Back Pain	☐	☐	Allergies	☐	☐
Hip Pain	☐	☐	Seizures	☐	☐
Scoliosis	☐	☐	Digestive Problems	☐	☐
Low Energy	☐	☐	Trouble Sleeping	☐	☐
Foot/Knee problems	☐	☐	Ulcers	☐	☐
Numbness in arms/hands	☐	☐	Low/High blood pressure	☐	☐
Tingling in arms/hands	☐	☐	Frequent cold/flu	☐	☐

Physical Trauma History

Have you ever had any significant falls, injuries, or surgeries?

◯ Y ◯ N If Yes, please explain: _____

Any Car Accidents:

◯ Y ◯ N If Yes, when, and what happened? _____

Did you/Do you play sports?

◯ Y ◯ N

Please list any significant family medical history: _____

How many children do you have? _____ How old are they? _____ Are you currently pregnant? ◯ Y ◯ N

Any health concerns? _____ Number of past pregnancies _____

Health concerns during pregnancy? _____

Does your child or spouse/partner already have an appointment?

☐ Yes, in the same week as mine
☐ Yes, I was referred by them
☐ No, but I'd like to schedule them
☐ No, but let's talk about that later

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Life Effect of your Symptoms

How are these symptoms/conditions interfering with your life?

	No Effect	Mild Effect	Moderate effect	Severe Effect
Work	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Recreation	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Energy	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Patience	☐	☐	☐	☐
Productivity	☐	☐	☐	☐

How committed are you to fixing this issue? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Health and Condition Goals

Briefly, if you could snap your fingers and make your symptoms go away, how would life be different TODAY?

What are your 1 YEAR health goals if your condition improves or symptoms are eliminated?

What are your 5 YEAR health goals if your condition improves or symptoms are eliminated?

What would you like to gain from chiropractic care?

Toxicity

Please rate your stress level in the following categories:

	None	Some	Moderate	High	Severe
Home	◯	◯	◯	◯	◯
Work	◯	◯	◯	◯	◯
Life	◯	◯	◯	◯	◯
Money	◯	◯	◯	◯	◯
Health	◯	◯	◯	◯	◯
Family	◯	◯	◯	◯	◯

Please list medications:

Please list supplements:

Please rate your consumption of each:

	None	Some	Moderate	A lot
Water	◯	◯	◯	◯
Alcohol	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯