Reactivation Application for Care

Is this appointment alone or with a family member?

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

Biological Sex: ◯ M ◯ F

Confidential Personal Information

First Name: ______________ Last Name: ____________________ Date Of Birth: ____________________

Cell: ________________________ Other Phone: ____________________ Email: ____________________

Street Address ___________________________________ City/State _______________ Zip ___________

Preferred Contact Method: ◯ Text me ◯ Call me

Emergency Contact: First Name: ____________________ **Last Name:** ____________________

Phone: ________________________ **Relationship:** ____________________

Marital Status

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

Name of Spouse: __________________________

How many children do you have? _______ How old are they? _______

Has any of the above information changed since your last appointment? __________________________

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

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

Trauma History

Have you had any accidents, falls, or traumas since you were last under our care?

____

Have you had any hospitalizations or surgeries since you were last under our care?

____

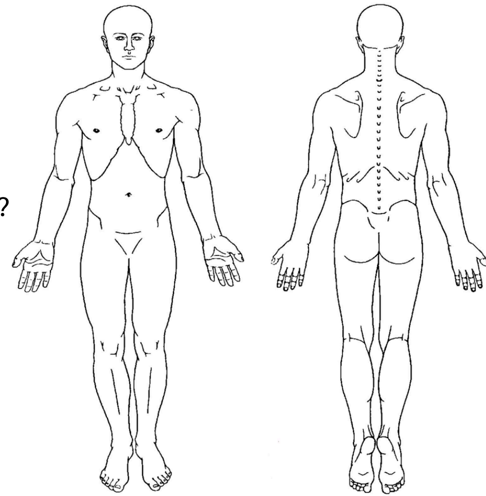
Have you had any major life changes (new job, new house, or new stressors) since you were last under our care?

____

Reactivation Application for Care

RESTORE FAMILY
CHIROPRACTIC

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



B: Burning

R: Radiating

A: Aching/Stiff

N: Numb

S: Stabbing

What is the purpose of today's appointment?

◯ Wellness Checkup ◯ Recent injury or accident
◯ Current or recent symptoms

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

____

How long ago did you first notice it? ________________

I first noticed this symptom:

◯ Suddenly ◯ Gradually ◯ post-injury

What were you doing when you first noticed it? ________________________________

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

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

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

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

What makes it worse? ______________________________________

Symptom Review

Past	Present		Past	Present	
☐	☐	Concussions	☐	☐	Swollen/Painful Joints
☐	☐	Headaches/Migraines	☐	☐	Dizziness
☐	☐	Neck Pain	☐	☐	Digestive Problems
☐	☐	Irritability/depression	☐	☐	Trouble Sleeping
☐	☐	Shoulder Pain	☐	☐	Frequent cold/flu
☐	☐	Upper Back Pain	☐	☐	Foot/Knee problems
☐	☐	Low Back Pain	☐	☐	Numbness in arms/hands
☐	☐	Hip Pain	☐	☐	Tingling in arms/hands