APPLICATION FOR CARE AT LIVESAY CHIROPRACTIC

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

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

Employer: _____ Occupation: _____ Enrolled in School ○ Yes ○ No

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY OF COMPLAINT

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

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 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

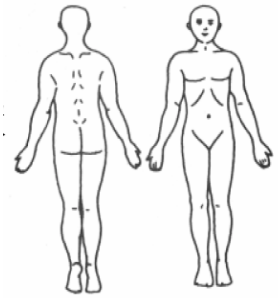
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

Name of previous chiropractor: _____ ☐ **N/A**



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

R = Radiating **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? _____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

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? _____

Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results. ○ Favorable ○ Unfavorable Please explain: _____

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:

P for in the ***Past*** **C** for ***Currently*** have **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	PROVIDED 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: _____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never

2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never

3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never

4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to Livesay 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 Livesay 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	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sit to Stand	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Climb Stairs	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Pet Care	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Extended Computer Use	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Lift Children/Groceries	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Read/Concentrate	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Getting Dressed	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Shaving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sexual Activities	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sleep	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Sitting	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Static Standing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Yard work	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Walking	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Washing/Bathing	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Sweeping/Vacuuming	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Dishes	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Laundry	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Garbage	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Driving	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform
Other: _____	O No Effect	O Painful (can do)	O Painful (limits)	O Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____ _____ - _____ - _____

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

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ DATE: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **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	___ Asthma
___ 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	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ 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)

_____ _____ - _____ - _____

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

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**