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

APPLICATION FOR CARE AT NORTH STAR FAMILY CHIROPRACTIC

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Fax:_____
Mobile Phone: _____ Work Phone: _____ Fax: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Occupation: _____ Names and Ages of your children: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is a : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Fourth** complaint: 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

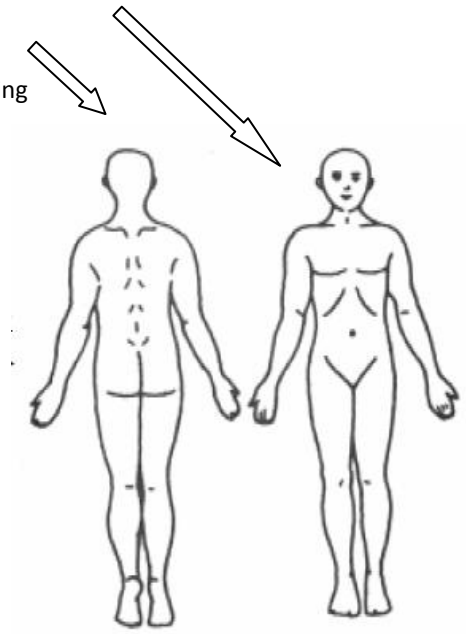
What relieves your symptoms? _____ what makes them feel worse? _____

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 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



is your problem the result of ANY type of accident? ☐ Yes, ☐ No **If yes** identify type:
☐ Auto ☐ Work ☐ Home ☐ Other (*please explain*):_____ _
Date of Accident: _____ - _____ - _ _____ approximate time of day? ____am _____pm
Have you reported this accident to anyone? ☐ No ☐ Yes **If yes** to whom:
_____
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? _____
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.
_____ _____
When was your most recent auto accident? _____
Speed on impact? _____ ☐ Front, ☐ side, **OR** ☐ rear-end collision?
Treatment received? ☐ YES ☐ NO **If yes**, by whom? _____

When was your most recent stress or strain at work? _____ Were you treated?

☐ YES ☐ NO I**f yes,** EXPLAIN: _____

Please list any other work related injuries or incidents prior to this one: _____

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:

_____

Identify all sports or recreational activities you participate in: _____

- When was your most recent stress or strain during your activity? _____
- Was any treatment received? YES / NO IF YES EXPLAIN:_____
- When was the one before that? _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

PAST HISTORY

1. 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 and **N** for *N**ever** have had*:

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

2. PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Reserved for doctor's use only Systems reviewed with patient:

❑Musculoskeletal ❑
❑Neurological ❑

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 you present problem affect the following:

IDENTIFY TYPE:	EFFECT:
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____	☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

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 North Star Family 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 North Star Family Chiropractic for any and all services I receive at this office.

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

NORTH STAR FAMILY CHIROPRACTIC

Patient's Name: _____ **HR#:** _____

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: _____

_____

Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ 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

Other: _____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

Patient signature: _____ Today's Date:

___/___/___
