Today's Date: _______________

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

APPLICATION FOR CARE AT ELITE CHIROPRACTIC

Is the patient now, or will he / she be eligible for Medicare/Medicaid in the next 6 months? ☐ Yes ☐ No

PATIENT DEMOGRAPHICS

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

Address: ____ City: _________________________________ State: _____ Zip: __________

E-mail Address: ____________________________________ Home Phone: ________________________Mobile Phone:_______________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: ______________________________

Social Security #: __________________________________ Driver's License #: ____

Employer: ____ Occupation: ____

Spouse's Name ____Spouse's Employer ____

Number of children and Ages: ____

Name & Number of Emergency Contact: ____Relationship: ___________________________

Previous Chiropractor ________________________________ ☐ **N/A** Last Visit: ___/___/_____ City/State: ________________________

HISTORY of COMPLAINT

☐ Wellness Check-Up ☐ Injury or Accident ☐ Other: Please explain: ____

List the health concerns in order of importance:	How long have you had it?	Seen another doctor for this complaint?
1. ____________________________________	____________________	☐ Yes ☐ No Date: ___/___/_____
2. ____________________________________	____________________	☐ Yes ☐ No Date: ___/___/_____
3. ____________________________________	____________________	☐ Yes ☐ No Date: ___/___/_____
4. ____________________________________	____________________	☐ Yes ☐ No Date: ___/___/_____

If you are experiencing Pain/Discomfort, please identify where and how long:

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 : 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? ☐ Specific Date: ___/___/_____ ☐ Unknown ☐ Gradual ☐ Sudden

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

Is the problem the result of ANY type of accident? ☐ Yes ☐ No, If 'Yes', ☐ Motor Vehicle ☐ Work ☐ Other

How did the injury happen?____

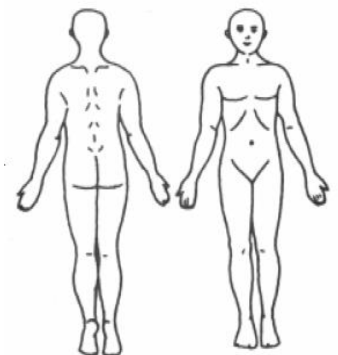
Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: ______ by whom? _______________________________

How long were you under care: ____________ What were the results? ____

***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 the symptoms? ____

What makes them feel worse? ____



ACTIVITIES OF DAILY LIVING

Patient Name: ______________________________________ **Date:** ________________________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

REVIEW OF SYSTEMS

Regarding the next section, **please circle Yes (Y), No (N) or Past (P)** regarding the following:

EYES		HEAD		NOSE	
Dry/Watery	Y N P	Headache	Y N P	Frequent Colds	Y N P
Double Vision	Y N P	Migraine	Y N P	Chronic Congestion	Y N P
Glaucoma	Y N P	Past Head Injury	Y N P	Polyps	Y N P
Dark Under Eyelids	Y N P	Hair Loss	Y N P	Nosebleeds	Y N P
Cataracts	Y N P	Dandruff	Y N P	Post Nasal Drip	Y N P
Styes	Y N P	Oil/Dry Hair	Y N P	Seasonal Allergies	Y N P

SKIN		MOUTH/ THROAT		RESPIRATORY	
Rash	Y N P	Canker Sores	Y N P	Cough	Y N P
Hives	Y N P	Sore Throat	Y N P	Wheezing	Y N P
Psoriasis/eczema	Y N P	Odd Taste	Y N P	Bronchitis	Y N P
Dry	Y N P	Chronic Dry Mouth	Y N P	Pneumonia	Y N P
Skin Cancer	Y N P	Cold Sores	Y N P	Asthma	Y N P
Abnormal Perspiration	Y N P	Gum Disease	Y N P		
Itchy	Y N P	Cavities	Y N P	Shortness of Breath:	
Warts/Moles	Y N P	Hoarseness	Y N P	with exertion	Y N P
		Swollen Glands	Y N P	at rest	Y N P

URINARY TRACT		GASTROINESTINAL		CARDIOVASCULAR	
Incontinence	Y N P	Diarrhea	Y N P	High Blood Pressure	Y N P
Frequent Infections	Y N P	Constipation	Y N P	Low Blood Pressure	Y N P
Urgency	Y N P	Heartburn	Y N P	Arrhythmias	Y N P
Discharge / Blood	Y N P	Indigestion	Y N P	Edema (swelling)	Y N P
Kidney Stones	Y N P	Bloating	Y N P	High Cholesterol	Y N P
		Nausea/Vomiting	Y N P	Murmurs	Y N P
Do you get up to urinate at night?	1x 2x 3x more	Recent BM Change	Y N P	Palpitations	Y N P
		Hemorrhoids	Y N P	Chest Pain	Y N P
		Gall Bladder Disease	Y N P		

MUSCULOSKELETAL		NERVOUS SYSTEM		EMOTIONAL HEALTH	
Weakness	Y N P	Paralysis	Y N P	Depression	Y N P
Stiffness	Y N P	Tingling/Numbness	Y N P	Suicidal	Y N P
Tremors	Y N P	Seizures	Y N P	Anxiety	Y N P
Arthritis	Y N P	Sciatica	Y N P	Eating Disorder	Y N P
Leg Cramps	Y N P	Carpal Tunnel Syndrome	Y N P	Anger/Irritability	Y N P
Pain	Y N P	Fainting	Y N P	High-Strung/Tense	Y N P
				Fear/Panic	Y N P
				Psychiatric Hospitalization	Y N P

MALE GENETALIA

Testicular Pain/Swelling	Y N P	Discharge	Y N P	Sexually Active	Y N P
				STD	Y N P

FEMALE GENETALIA

Age Periods Began	________	Last Pap Smear (month/yr)	___/_____	Sexually Active	Y N P
How long Period Lasts	________	Any Abnormal Paps	Y N P	Vaginal Dryness	Y N P
Menstrual Cramping	Y N P			Vaginal Itching/Irritation	Y N P
PMS	Y N P	Times Pregnant	_________	STD	Y N P
How Often Period Occurs	________	How many births	_________	Vaginitis	Y N P
Heavy Menstrual Bleeding	Y N P	Miscarriages	Y N P		
				Mammography	Y N P

Current Method of Birth Control: ____

Hormonal Birth Control Used in the Past and How Old You Were: ______________________________

PAST HISTORY

PREVIOUS SURGERIES AND HOSPITALIZATIONS

1. ____ Date Occurred: ___________________ Outcome: ______________________
2. ____ Date Occurred: ___________________ Outcome: ______________________
3. ____ Date Occurred: ___________________ Outcome: ______________________
4. ____ Date Occurred: ___________________ Outcome: ______________________
5. ____ Date Occurred: ___________________ Outcome: ______________________

KNOWN ALLERGIES
(medications, environment, foods)

1. ____ Last Date Occurred: ______________ Severity: ______________________
2. ____ Last Date Occurred: ______________ Severity: ______________________
3. ____ Last Date Occurred: ______________ Severity: ______________________
4. ____ Last Date Occurred: ______________ Severity: ______________________
5. ____ Last Date Occurred: ______________ Severity: ______________________

LAB TESTS AND IMAGING

Most Recent Procedures:

Bloodwork Assessment: ❑ Never ______________, 20____ Results: ___________________________________
Physical Exam: ❑ Never ______________, 20____ Results: ___________________________________
X-Rays: ❑ Never ______________, 20____ Results: ___________________________________
MRI/CT ❑ Never ______________, 20____ Results: ___________________________________
Ultrasound ❑ Never ______________, 20____ Results: ___________________________________
HIV Test ❑ Never ______________, 20____ Results: ___________________________________
Dental Visit ❑ Never ______________, 20____ Results: ___________________________________
Eye Exam ❑ Never ______________, 20____ Results: ___________________________________

MEDICATIONS

Antacids ❑ Yes ❑ No ❑ Previously **Over-the-Counter Pain Meds.** ❑ Yes ❑ No ❑ Previously
Steroids ❑ Yes ❑ No ❑ Previously

Current prescription or over the counter medications (please attach additional paper if needed)

Medication and Dose	Reason Prescribed	Prescriber	Length of Time Taking This Medication	Side Effects Experienced
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Other major illnesses, slips/falls, broken bones, injuries: ____

____

____

____

____

SOCIAL HISTORY

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ______________________ What speed was the collision? __________mph
Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact Was treatment received? ❑ Yes ❑ No

When was your most recent strain / stress at work? ________________ Type of Injury: __________________________________
Was treatment received? ❑ Yes ❑ No If 'Yes', Please describe ____
Does your job require you remain in long term stressful postures?____

Collision, quick burst, or repetitive motion sports:
- ❑ football ❑ wrestling ❑ basketball ❑ baseball
- ❑ soccer ❑ tennis ❑ golf ❑ track and field
- ❑ Other: ______________________________

Trauma as a child:
- ❑ fall on your head ❑ impact to your head ❑ Concussion
- ❑ fall onto your back or tailbone
- ❑ biking accident
- ❑ Other: ____

Work around the house – lifting, bending, woke up with stiff neck, "back went out": ______________________________________

INITIAL NUTRITIONAL PROFILE

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? ❑ Yes ❑ No

What special diet do you follow, if any? ❑ Vegetarian ❑ Vegan ❑ Food Allergy ❑ Atkins ❑ Other: _______________________

Eating Habits (check any that apply):
- ❑ Skip Breakfast, if Yes, how many days per week? 0 1 2 3 4 5+
- ❑ 3 meals per day ❑ Eat constantly whether hungry or not
- ❑ 2 meals per day ❑ Crave sweet
- ❑ Graze (small, frequent meals) ❑ Crave salt
- ❑ Generally eat on the run

What do you drink during the day, how much?
- ❑ Coffee ______ ❑ Soda _______ ❑ Juice ______ ❑ Tea ______ ❑ Water ______ ❑ Other _____

How often do you eat at restaurants? ____
How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)
- ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7+

How many servings of vegetables do you have on a given day?
- ❑ 0-1 ❑ 2-3 ❑ 4-5

How many servings of fruit do you have on a given day?
- ❑ 0-1 ❑ 2-3 ❑ 4+

Have you tested with high triglycerides or high cholesterol? ❑ Yes ❑ No Values?______________
Have you tested with high blood pressure? ❑ Yes ❑ No

INITIAL FITNESS PROFILE

How many days per week do you exercise?
- ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7+

Cardiovascular ___Hours ___Days/Wk
Weight Training ___Hours ___Days/Wk
Low Impact (Yoga, etc.) ___Hours ___Days/Wk

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) ________

Hobbies: ____

Present Weight: ________ Ideal Weight ________ Maximum Weight and When: ____________________________________

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? ❑ Yes ❑ No
Have you ever noticed mold growing in your home or your place of work? ❑ Yes ❑ No
Does your home, work, school, or car have damp or mildew smell? ❑ Yes ❑ No

Have you received a full standard profile of vaccinations? ❑ Yes ❑ No

Do you receive yearly flu shots? ❑ Yes ❑ No
How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? ❑ Yes ❑ No

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to?
____

Have you had any job where you were exposed to solvents, heavy metals, fumes or other toxic materials? If yes, please list:
____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?
____

Are you particularly sensitive to perfumes, gasoline or other vapors? ❑ Yes ❑ No ______________________

Do you use pesticides, herbicides or other chemicals around your home? ❑ Yes ❑ No ______________________

INITIAL STRESS PROFILE

Sleep

Do you get an average of 8 hours of sleep per night ❑ Yes ❑ No
Do you average less than 7 hours of sleep per night ❑ Yes ❑ No
Do you ever take pills to go to sleep or relax ❑ Yes ❑ No
Do you:

Sleep Walk ❑ Yes ❑ No   Wake Refreshed ❑ Yes ❑ No
Have Nightmares ❑ Yes ❑ No   Must Nap ❑ Yes ❑ No
Grind Teeth ❑ Yes ❑ No .

Stress

Do you often feel short on time and procrastinate on projects? ❑ Yes ❑ No
Do you experience feelings of anxiety about completing tasks? ❑ Yes ❑ No
Do you feel like you don't give enough time or attention to important areas in your life like family or a hobby? ❑ Yes ❑ No
Do you rely more on your memory than a planner and action list to get things done? ❑ Yes ❑ No
Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

TOBACCO

Do you smoke or chew tobacco? ❑ Yes ❑ No ❑ Prev.
Number of Cigarettes ____ Per Day/Week/Month
Number of Cigars ____ Per Day/Week/Month
Amount of Chewing Tobacco ____ Per Day/Week/Month
Age When Started: _______
Does anyone in your workplace smoke? ❑ Yes ❑ No

ALCOHOL

Do you drink alcohol? ❑ Yes ❑ No ❑ Previously
How often and how much if "Yes" or "Previously": ______________________
Alcohol Use: _______ drinks per day / week / month

SOCIAL LIFE

Please rate your energy on a scale of 1-10 (1 = poor, 10 = excellent): 1 2 3 4 5 6 7 8 9 10

If you are troubled by daytime fatigue, at what time do you experience this? _________ AM / PM

Stress Level (1=best, 10=worst): 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress? ______________________
____

If you have a partner, what is the quality of your relationship? ______________________

FAMILY HISTORY:

	Father	Mother	Siblings	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Age if living	______	________	________	________	________	________	________
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack / Stroke	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Asthma / Allergies	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N	Y N	Y N	Y N	Y N

I hereby authorize payment to be made directly to Elite 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 Elite Chiropractic for any and all services I receive at this office.

________________________________ ________________________________ _____/____ /________

Patient's Name **Guardian's Name** **Date Completed**

________________________________ ________________________________

Patient or Guardian's Signature **Relationship to Patient**

____________________________________ ______ - ______ - _____

Doctor's Signature **Date Form Reviewed**