Whom may we thank for referring you to our office? ____

Application for Chiropractic Care at Beacom Family Chiropractic

Today's Date: __________________________

Patient Information

Name: ______________________________________ Birth Date: ___/___/____ Age: _____ Ht: _____ Wt: _____

Address: ____________________________________ City: ____________________ State: _______ Zip: ________

Email: _______________________________ Home Phone: _______________ Cell Phone: ___________________

Male: _________ Female: ________ Social Security #: ____

Employer: _____________________________ Occupation: _________________ Work Phone: _______________

Marital Status: Single___ Married___ Spouse Name: __________________ Spouse Employer: ________________

Number of Children and Ages: ____

Name & Number of Emergency Contact: ____________________________ Relationship: ____________________

History of Complaint

Primary Complaint: __________________________________ Secondary: __________________________________

Third: ____ Fourth: ____

On a scale of **1-10** with **1** being mild pain and **10** being severe pain, rate your above complaints:

Primary Complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second Complaint: 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? ____ Is it getting worse? Y / N

When is the problem at its worst? **AM** **PM** **Mid-Day** **Late Night**

Frequency of the problem: Constant: ________ Intermittent: ________ No Consistent Pattern: ________

Quality of Pain (check all that apply): __Sharp __ Stabbing __ Dull __ Achy __ Tight __ Numbness __ Burning

What does your condition interfere with: __ Work __ Sleep __ Daily Routine __ Sitting __ Standing

What relieves your symptoms: ____

What aggravates your condition: ____

Pregnancy/Birth Process

Did your mother smoke, drink alcohol or do drugs during pregnancy? Y / N

Did your mother have any falls or injuries during pregnancy? Y / N

Check all that apply: __ Hospital Birth __ Home Birth __ Breach __ C-Section __ Forceps __ Induced Labor

Other: ____

Past Injury/Accident History

Is your condition the result of an accident: Y / N Explain: _______________________________________

Identify any other injuries to your spine, minor or major, that the doctor should know about:

____

____

____

Have you suffered from this or a similar problem in the past: Y / N (If Yes) Explain: ____________________

____

What surgeries have you had: ____

What medications do you take: ____

Please list other health conditions: ____

Are there any family/hereditary health issues: ____

Lifestyle History

Please check all that apply: ____ Smoke ____ Drink Alcohol ____ Drug Use

Please explain diet/nutritional plan:

____

Do you have mental/emotional stress:

____

Do you exercise regularly: Y / N   Name of program/Type of exercise:

____

Dr. Notes:

____

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