Essential Family CHIROPRACTIC

PRACTICE MEMBER APPLICATION

Name: _____ Email Address: _____

If practice member is a minor, parent name(s): _____

Date of Birth: _____/_____/_____ Age: _____ Male / Female Today's Date: _____/_____/_____

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

Cell Phone: _____ Home Phone: _____

Preferred Method of Communication (check one): □ Email □ Text □ Cell Phone □ Home Phone

Occupation: _____ Student / Full Time Parent / Retired From: _____

Employer's Name: _____

Marital Status: S M D W Spouse's Name: _____ Number of Children: _____

Names, Ages & Gender: _____

__WOMEN ONLY__ *For x-ray purposes, is there any possibility that you could be pregnant? YES / NO*

If yes, how far along? _____ Due Date: _____

Who may we thank for referring you? _____

WHAT BRINGS YOU IN TODAY? PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU SEEN ANY MEDICAL DOCTORS FOR THESE CONDITIONS? YES / NO

IF YES, WHEN? _____

HAVE YOU PREVIOUSLY SEEN A CHIROPRACTOR? YES / NO DATE OF LAST SPINAL XRAYS: _____

IF YES, WHO AND WHEN WERE YOU LAST ADJUSTED? _____

LIST ALL SURGICAL OPERATIONS AND YEARS:

_____

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU TAKE / LAST ROUND OF ANITBIOTICS (DATE)

_____

_____

LIST ALL TRAUMAS (AUTO ACCIDENTS, SLIPS, FALLS, SPORTS, EXERCISE) AND DATES:

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO **FRACTURED A BONE? YES / NO**

IF YES, PLEASE DESCRIBE: _____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:			
STROKE	**CANCER**	**HEART DISEASE**	**SPINAL SURGERY**
SEIZURES	**SPINAL BONE FRACTURE**	**SCOLIOSIS**	**DIABETES**

CIRCLE ALL *CURRENT* PROBLEMS YOU HAVE:

DIZZINESS/VERTIGO	TMJ / JAW PAIN	MID BACK PAIN	LOW BACK PAIN	DISC PROBLEMS
HEADACHES	SHOULDER PAIN	NUMBNESS IN ARMS	NUMBNESS IN LEGS	HIP/PELVIC PAIN
NECK PAIN	ARM PAIN	NUMBNESS IN HANDS	NUMBNESS IN FEET	SCIATICA
MUSCLE SPASMS	MUSCLE WEAKNESS	KNEE PAIN	LEG PAIN	SCOLIOSIS
NAUSEA	SINUS ISSUES	CHEST PAIN	MENSTRUAL CRAMPS	BLADDER PROBLEMS
ANXIETY	RINGING IN EARS	HEART DISORDERS	MENSTRUAL IRREGULARITY	PLANTAR FASCIITIS
DEPRESSION	THROAT ISSUES	HIGH/LOW BLOOD PRESSURE	INFERTILITY/MISCARRIAGE	SHORTNESS OF BREATH
NERVOUSNESS	THYROID ISSUES	ALLERGIES	KIDNEY PROBLEMS	FREQUENT COLDS
EPILEPSY/SEIZURES	EAR INFECTIONS	CHRONIC FATIGUE	ASTHMA	FIBROMYALGIA
ADD/ADHD	INSOMNIA	DIGESTIVE ISSUES	LIVER DISEASE	VISION CHANGES
ARTHRITIS	ECZEMA/RASH	ACID REFLUX/ULCERS	PROSTATE ISSUES	SWELLING IN JOINTS

SOCIAL HISTORY | DO YOU…

SMOKE? YES / NO HOW OFTEN? _____

EXERCISE? YES / NO HOW OFTEN? _____, MILD / MODERATE / INTENSE

HOW DOES YOUR CURRENT PROBLEM AFFECT YOUR FAMILY LIFE, WORK, HOBBIES, ETC?

_____

_____

WHAT ARE YOUR HEALTH GOALS? HOW WILL THEY CHANGE YOUR LIFE ONCE ATTAINED?

_____

_____

BIRTH & CHILDHOOD HISTORY

How were you (the patient) born?

Any complications during your birth process or mother's pregnancy?	**YES / NO**	Details:		
Type of birth:	**C-Section**	**Vaginal**	How long was labor and delivery?	
What did the care provider use to assist in delivery?	**Hands**	**Vacuum**	**Forceps**	**Unassisted**
Were you vaccinated?	**YES / NO**	List any reactions/injuries (ex: fever):		
Did you have any early health challenges?	**YES / NO**	Details:		
Did you have any concerning trips or falls?	**YES / NO**	Details:		
List any over-the-counter or prescription medications frequently used as a child	**YES / NO**	Details:		
Did your parents worry often about your health?	**YES / NO**	Due to health issues, did you miss school and other activities?	**YES / NO**	Details:

Circle all symptoms you experienced as a child:

Trouble Sleeping	**Ear Infection**	**Colic/Reflux**	**Allergies**	**Abnormal Skull Shape**
Frequent Tantrums	**Bedwetting**	**Fevers**	**ADHD**	**Trouble Concentrating**
Weak Heartbeat	**Racing Heart**	**Murmur**	**Torticollis**	**Digestive Problems**
Breathing Problems	**Birth Trauma**	**Seizures**	**Asthma**	**Known Vaccine Reaction**

Other:_____

FAMILY HISTORY

CONDITION	MOTHER	FATHER	CHILDREN	SPOUSE
Arthritis				
Asthma/Allergies/Sinus Trouble				
ADD/ADHD				
Bed Wetting				
Cancer				
Carpal Tunnel				
Deceased				
Diabetes				
Digestive Problems/Heartburn				
High Blood Pressure				
Ear Infections				
Fibromyalgia				
Headaches/Migraines				
Neck Pain/Back Pain/Disc Problems				
Menstrual Problems				
Scoliosis				
TMJ				