PATIENT APPLICATION FOR CARE

Patient Information

Name ______________________________________
Address ____________________________________
City _________________State_______Zip _______
Home Phone____________________Height ______
Cell Phone _____________________Weight______
Soc. Sec. No. _______________________________
Date of Birth ____________________Age________
Email ______________________________________
Employer ___________________________________
Business Phone______________________________
Occupation _________________________________
Marital Status: M S W D # Children________
Spouse's Name ______________________________

Guarantor Information If Other Than Patient

Name _______________________________________
Address _____________________________________
City _________________State _______Zip________
Home Phone _________________________________
Soc. Sec. No._________________________________
Date of Birth ________________________________
Employer ____________________________________
Business Phone ______________________________
Occupation___________________________________
Marital Status: M S W D # Children________
Spouse's Name________________________________

Who referred you to our office? _________________________________

- -

INSURANCE INFORMATION: Please Check which applies: Work____ Auto Accident____ Other____

Primary Carrier______________________________
Address____________________________________
City _________________State________Zip_______
Phone No.__________________________________
Policy ________________Group________________
Enrollee___________________Birthday__________
Soc. Sec. No.________________________________

Secondary Carrier ____________________________
Address ____________________________________
City________________State_______Zip_________
Phone No.___________________________________
Policy _______________Group________________
Enrollee __________________Birthday__________
Soc. Sec. No. _______________________________

- -

WHAT IS YOUR HEALTH PHILOSOPHY? ____

HOW DO YOU WANT US TO HANDLE YOUR PROBLEM? Maximum Correction_____ Temporary Relief _____

WHAT ARE YOUR EXPECTATIONS OF US?____

X-RAY CONFIRMATION: I consent to spinalgraphic x-rays. I understand that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant.

PATIENT SIGNATURE____**DATE**__________________________

Are you Right or Left handed?

Fees are payable when services received unless special arrangements are made in advance.

Hales Chiropractic Center - 360 S. State St. Suite-A - Clearfield, UT 84015 - 801-773-1821

PATIENT APPLICATION FOR CARE

A. Previous injuries or trauma:

_____

B. Previous illnesses you've had in your life:

_____

C. Have you broken any bones? Which?

_____

D. List any surgeries you've had:

_____

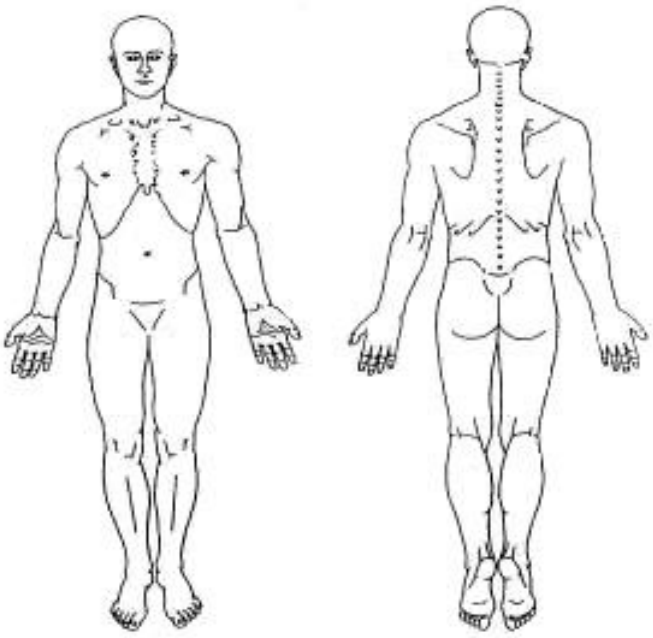
E. Do you have any allergies?

_____

F. Are you on any medications? circle one: No Yes (see below)

Medication:	Reason for taking:	Medication:	Reason for taking:

Indicate areas of pain with
M=Mild **X**=Moderate **S**=Severe **N**=Numb



Habits	Alcohol	Caffeine	Tobacco	Sweets	Exercise
Heavy	_____	_____	_____	_____	_____
Moderate	_____	_____	_____	_____	_____
Light	_____	_____	_____	_____	_____
None	_____	_____	_____	_____	_____

PAST - O or PRESENT- X CONDITIONS

___Fractured Bones
___Auto Accidents
(a)____0-5 yrs ago
(b)____More than 5 yrs ago
___Knocked Unconscious
___Diabetes
___Swollen or Painful Joints
___Convulsions/Epilepsy
___Itching
___Bruise Easily
___Cancer
___Frequent Colds/Flu
___Nervous, Depressed, Irritable
___Anemia
___Tremors
___Allergy
___Sinus Problems
___Light Headed Upon Arising
___Under Stress
___Crave Sweets or Salt
___Trouble Sleeping
___Trouble Concentrating
___Loss of Memory
___Learning Disability
___Headache
___Neck Pain or Stiffness
___Numbness, Tingling or pain in arms, hands, fingers R__ L__
___Jaw Pain, Click (TMJ) R__ L__
___Shoulder Pain R__ L__
___Dizziness
___Loss of Balance
___Blurred or Double vision R__ L__
___Upper back Pain or Stiffness R L
___Mid back Pain or Stiffness R L
___Low back Pain or Stiffness R L
___Numbness/tingling/pain in buttocks, thighs, legs, feet, toes R__ L__
___Hip Pain R__ L__
___Chest Pain
___Asthma
___Difficult Breathing
___Heart Problems
___Stroke
___High or Low Blood Pressure
___Gall Bladder Trouble
___Belching/Bloating/Excessive Gas
___Heartburn
___Ulcers
___Diarrhea/Constipation
___Colon Trouble
___Prostate Problems
___Impotence
___Kidney Stones
___Painful Frequent Urination
___Discharge
___Menopausal/PMS Problems
___Breast Lumps, Soreness
___Pregnant (now)
___Bedwetting
___Ear Infections
___AIDS/HIV

The above information is true and accurate to the best of my knowledge:

Signature: _____ Date: _____

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PATIENT SYMPTOM FORM

Patient Name: _____ Date: _____

1. What is the <u>MAIN</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

- When did the symptom begin (date or approximately how long ago)? _____
  - Did the symptom begin: -suddenly or -gradually? (circle one)
  - How did the symptom begin (What happened)? _____
- What makes the symptom worse? _____
  _____
- What makes the symptom better? _____
  _____
- Describe the quality of the symptom (circle all that apply):
  - Dull, achy, deep, burning, throbbing, sharp, piercing, stabbing, stinging, shooting, stiffness
    Other (please describe): _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Does the symptom radiate to another part of your body (circle one): YES NO
  - If yes, where does the symptom radiate? _____

2. What is the <u>NEXT most bothersome</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

- When did the symptom begin (date or approximately how long ago)? _____
  - Did the symptom begin: -suddenly or -gradually? (circle one)
  - How did the symptom begin (What happened)? _____
- What makes the symptom worse? _____
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  - Dull, achy, deep, burning, throbbing, sharp, piercing, stabbing, stinging, shooting, stiffness
    Other (please describe): _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Does the symptom radiate to another part of your body (circle one): YES NO
  - If yes, where does the symptom radiate? _____

Patient Name: _____ Date: _____

3. What is the <u>NEXT most bothersome</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

- When did the symptom begin (date or approximately how long ago)? _____
  - Did the symptom begin: -suddenly or -gradually? (circle one)
  - How did the symptom begin (What happened)? _____
- What makes the symptom worse? _____
  _____
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  - Dull, achy, deep, burning, throbbing, sharp, piercing, stabbing, stinging, shooting, stiffness
    Other (please describe): _____
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Does the symptom radiate to another part of your body (circle one): YES NO
  - If yes, where does the symptom radiate? _____

4. What is the <u>NEXT most bothersome</u> problem/symptom you are having? _____

On a scale from 0-10, with 10 being the worst, please <u>circle the number</u> that best describes the **pain** most of the time: 0 1 2 3 4 5 6 7 8 9 10 Key: 0 = No pain at all 10 = Pain as bad as it could be (i.e. Call 911)	Circle the **one** that **best** describes how often you have your pain: 1. All of the time (constant) 2. Most of the time (near constant) 3. A good bit of the time (3-4 days/week) 4. Some of the time (less than 3 days/week) 5. A little of the time (1 day/week) 6. Hardly any of the time (less than 4 days/month) 7. None of the time

- When did the symptom begin (date or approximately how long ago)? _____
  - Did the symptom begin: -suddenly or -gradually? (circle one)
  - How did the symptom begin (What happened)? _____
- What makes the symptom worse? _____
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Signature: _____ Date: _____