

**APPLICATION FOR CARE**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City /State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Who told you about Atkinson Family Chiropractic? \_\_\_\_\_

Name and # of Emergency Contact: \_\_\_\_\_

Have you ever received Chiropractic care? **Y N** With whom? \_\_\_\_\_

Do you have a family medical doctor? **Y N** Who? \_\_\_\_\_ Last medical exam: \_\_\_\_\_

WOMEN: Are you pregnant? **Y N** Date of last menstrual period: \_\_\_\_\_

What do you wish to gain from Chiropractic care? \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Current health complaints/reason for consulting our office:

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

Were other doctors seen for this condition? **Y N** Who? \_\_\_\_\_ Results: \_\_\_\_\_

Has this condition occurred before? **Y N** When? \_\_\_\_\_

Are your injuries the result of an accident? **Y N** How did it occur? \_\_\_\_\_

Drugs currently taking (**circle all that apply**): Prescription Over-the-counter Antibiotics Other

Describe: \_\_\_\_\_

Please describe your daily activities for work, home, or school such as sitting, lifting, phone use, etc.:

**PAST HEALTH HISTORY**

Have you had an accident, even as a passenger, in a(n) (**circle all that apply**):

Automobile      Motorcycle      Bicycle      Other

Explain with dates: \_\_\_\_\_

Medical interventions (**circle all that apply**):

Hospitalizations      Surgery      Physiotherapy      Organ Removal      Other

Explain with dates: \_\_\_\_\_

Falls (**circle all that apply**):

Tree      Bicycle      Skates      Steps      On ice      Abuse

Broken Bones      Physical fight      Armed forces      Unconscious      Sports injuries

Explain with dates: \_\_\_\_\_

**APPLICATION FOR CARE**

Do you consume:    Alcohol            Coffee/caffeine            Tobacco            Recreational drugs

If so, how much? \_\_\_\_\_

Exercise:    **None**    **Moderate**    **Daily**    Diet:    **Poor**    **Fair**    **Good**

**Have you ever had any of the following diseases? (circle all that apply):**

Heart Disease            Chicken Pox            Polio            Tuberculosis            Epilepsy  
Diabetes            Cancer            Sexually Transmitted Diseases            HIV/AIDS

**Circle any of the following conditions you have had in the past six months:**

**Musculo-skeletal**

Low Back Pain  
Pain Between Shoulders  
Neck Pain  
Arm Pain  
Joint Pain/Stiffness  
Walking Problems  
Difficulty Chewing/Clicking Jaw  
General Stiffness  
Arthritis

**Nervous System**

Nervous  
Numbness  
Paralysis  
Dizziness  
Forgetfulness  
Confusion/Depression  
Fainting  
Convulsions  
Cold/Tingling Extremities  
Stress

**General**

Fatigue  
Allergies  
Loss of Sleep  
Fever  
Headaches

**EENT**

Vision Problems  
Dental Problems  
Sore Throat  
Earaches  
Hearing Difficulties  
Stuffed Nose

**Gastrointestinal**

Poor/Excessive Appetite  
Excessive Thirst  
Frequent Nausea  
Vomiting  
Diarrhea  
Constipation  
Hemorrhoids  
Liver Problems  
Gall Bladder Problems  
Weight Trouble  
Abdominal Cramps  
Gas/Bloating After Meals  
Heartburn  
Black/Bloody Stools  
Colitis

**Genito-urinary**

Bladder Trouble  
Painful/Excessive Urination  
Discolored Urine  
Kidney Stones

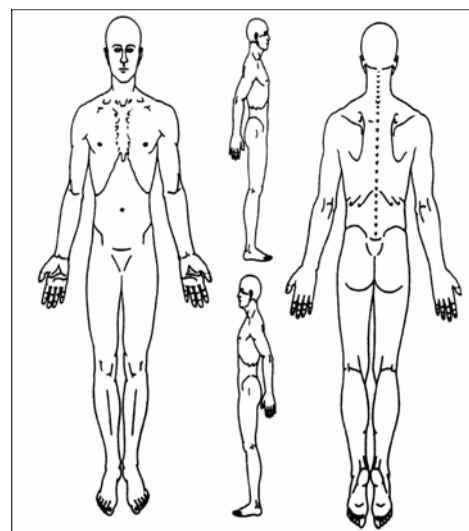
**Cardiovascular**

Chest Pain  
Shortness of Breath  
Blood Pressure Problems  
Irregular Heartbeat  
Heart Problems  
Lung Problems/Congestions  
Asthma  
Varicose Veins  
Ankle Swelling  
Stroke

**Male/Female**

Menstrual Irregularity  
Menstrual Cramps  
Vaginal Pain  
Vaginal Infections  
Breast Pain/Lumps  
Prostate Problems  
Sexual Dysfunction  
Other Problems

**Please outline the area(s) of your discomfort**



\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date