Neuro Renovations Chiropractic & Acupuncture
Initial Application for Care

Today's Date: _______/________/________________ Account Number: ____________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: ______/______/________ Age: _______ ☐ Male ☐ Female

Address: ____ City: ________________________________ State: _____ Zip: ___________

E-mail Address: ___________________________________ Phone #: _______________________

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

Is todays visit the result of an accident? ☐ Yes ☐ No **If yes**, please provide claim number: ____________________________________

Emergency Contact Name/ number: ____________________________/_____________________ Relationship: ___________________

Primary care physician ____ Doctor's Phone_____________________________________

How did you hear about our office? ____

MAJOR COMPLAINT

Primary Complaint:___________________________________ Secondary Complaints:_____________________________________

____ ____

____ ____

On a scale of **0** to **10** with **ZERO** being no pain and 10 being the worst possible pain, rate your above complaints by ***selecting the number***:

Primary complaint is: ☺ 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ☹

Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ______/_____/_______ How did it happen? ____

____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late night

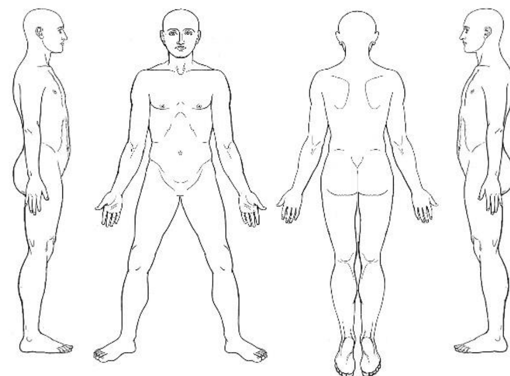
How long does it last? ☐ Constant ☐ Off and on during the day

What does it feel like? ____

ON THE DIAGRAM please mark your symptoms using the following letters:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness

S = Sharp/**S**tabbing **T = T**ingling



What relieves your symptoms? ____

What makes your symptoms worse? ____

Previous treatments done?____

-By whom? ____

-What were the results? ____

Previous diagnostic testing done? ____

-Results of tests done? ____

Any other facts about this current issue that you feel the doctor should know about?

____

____

PAST HISTORY

Have you experienced this problem or a similar problem in the past? ☐ Yes ☐ No **If yes,** how many times? _________ When was the last episode? _____________________ How did it happen before? ____

Treatment for previous episodes? ☐ Yes ☐ No **If yes,** what type of treatment? ____

Who provided it? _________________________ How long ago? ________________What were the results. ☐ Favorable ☐ Unfavorable

Please explain ____

Please list any and all jobs and activities that you have done in the past, or currently do, that have imposed physical stress on your body:

____

____

____

Please mark if you have **EVER HAD** any of the following conditions. Use the comments section to provide details:

Illnesses:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Tumors
- ☐ Blood Clots
- ☐ Heart Attack
- ☐ Autoimmunity
- ☐ CVA/TIA (stroke)
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other_______

Injuries:
- ☐ Broken bones
- ☐ Concussion
- ☐ Dislocation
- ☐ Car accident
- ☐ Other_______

Hospitalizations:
(Please include date)

____
____
____

Surgeries:
- ☐ Cancer
- ☐ Orthopedic
- ☐ Spinal
- ☐ Other_____________

Comments:

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FAMILY HISTORY

Place an "X" next to all that apply, use comments section to elaborate.

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling	Sibling	Child	Child	Other	Other
Gender	**F**	**M**						
Age at Death								
Aneurysm								
Stroke								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other								

Comments:

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SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Other

Spouses name: ______________________________________

Children: ☐ Yes ☐ No *How many?* _____________________

Employed? ☐Yes ☐No Occupation: ____________________

Employer: ____

Student Status: ☐ Full time ☐ Part time ☐ Non-student

Highest level of Education: ___________________________

Exercise frequency *Type?*_____________________________

☐ Daily ☐ 3-4xs/wk ☐ 1-2xs/wk ☐ Rarely ☐ Never

Caffeine Usage

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Tobacco Usage *Type and amount?*____________________________

☐ Daily ☐ Occasional ☐ Former ☐ Never

Alcohol Usage

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Recreational Drug Usage

☐ Daily ☐ Occasional ☐ Former ☐ Never

Comments:____
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____
____

MEDICATIONS/SUPPLEMENTS

Please list all medications, drugs, and supplements you currently take, the dosage, and the reason you take them: ______________________

____
____
____
____
____
____

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities of your daily life:

ACTIVITY:	EFFECT:			
Carry/Lift Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Tend to Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Washing/ Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Washing Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Taking out Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Doing Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Other_____________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Other_____________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform
Other_____________________	☐ No Effect	☐ Painful (can do)	☐ Painful (limited)	☐ Unable to Perform

Comments on any of the above tasks:____

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ALLERGIES

Do you have any allergies to medications, supplements, foods, or other? ☐No known allergies ☐Yes **If Yes**, please provide details on what the allergy is to, symptoms you experience, what you currently do for treatment, and if it is well controlled or not.

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REVIEW OF SYSTEMS

For the following list of symptoms, please mark **"P"** for in the **Past**, **"C"** for **Currently** have, or **leave blank** for **Never.**

Neurological
___Headache
___Dizziness
___Convulsions
___Seizures
___Tremors
___Fainting
___Balance issues
___Numbness
___Tingling
___Depression
___Irritability
___Anxiety
___Mood changes
___Learning disorders
___ADD/ ADHD

Head, Eyes, Ears Nose, Throat
___Double vision
___Blurred vision
___Ringing in the ears
___Hearing loss

Musculoskeletal
___Back pain
___Neck pain
___Hip pain
___Knee pain
___Foot/ankle pain
___Shoulder pain
___Elbow pain
___Wrist/hand pain
___Jaw pain/ TMJD
___Scoliosis
___Flat feet
___Muscle weakness

Respiratory
___Allergies
___Asthma
___Persistent Cough
___Difficulty breathing
___Chest pain
___Wheezing
___Lung problems
___Sinus/drainage problems

Gastrointestinal
___Loss of appetite
___Blood in stool
___Nausea/vomiting
___Abdominal pain
___Diarrhea
___Constipation
___Heartburn

Genitourinary
___Frequent urination
___Painful urination
___Blood in urine
___Loss of bladder control
___Bedwetting
___Irregular urine color

Cardiovascular
___Chest pains/tightness
___Rapid heartbeat
___Changing heartbeat
___Swelling of hands/feet
___High blood pressure
___Low blood pressure

Other
___Pregnant(currently)
___Rash/itching skin
___Non-healing sores
___Breast pain/lump
___Irregular periods
___Menopausal issues
___Infertility
___Sexual dysfunction
___Weight problems
___Recent weight change
___Fatigue
___Trouble Sleeping
___Eating Disorders
___Frequent colds/sickness
___Organ problems
___Hair Loss
___Sensitivity to light
___Other_______________
___Other_______________
___Other_______________

Please provide further details for any of the above mentioned symptoms here:_______________________

____
____
____

GOALS OF TREATMENT

Please mark what your goal is for seeking treatment with us currently:

☐ Get out of pain
☐ Get back to my normal life activities
☐ Fix the Problem
☐ Become Truly Healthy
☐ Other

Comments:
____
____
____
____
____

What do you anticipate being the biggest barrier for you in reaching your goals?

☐ Time
☐ Money
☐ Commitment
☐ Other

Comments:
____
____
____
____

I have answered the above questions to the best of my ability, and certify them to be true and accurate to the best of my knowledge.
I hereby authorize payment to be made directly to Neuro Renovations Chiropractic & Acupuncture, 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 Neuro Renovations Chiropractic & Acupuncture for any and all services I receive at this office.

____
Patient or Authorized Person's Signature

Date Completed

____
Doctor's Signature

______ / ______ /____________
Date Form Reviewed