



Whom may we thank for referring you to this office? _____

APPLICATION FOR CARE AT Infinite Health Center

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

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

E-mail Address: _____ Home Phone: _____ Mobile : _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

Primary or chief 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

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

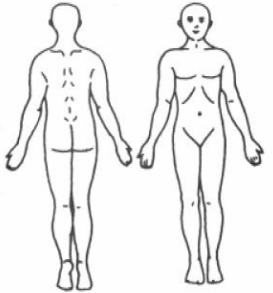
Name of Previous Chiropractor: _____ N/A

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? Yes, No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability
___ Cancer ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never

2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never

3. **Recreational Drug use:** Daily Weekends Occasionally Never

4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? No Yes

If yes whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)

Have they ever been treated for their condition? No Yes I don't know

2. **Any** other hereditary conditions the doctor should be aware of? No Yes: _____

I hereby authorize payment to be made directly to Infinite Health Center, 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 Infinite Health Center for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: __/__/__

Continued on next page

REVIEW OF SYSTEMS

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

<input type="checkbox"/> Headache	<input type="checkbox"/> Pregnant (Now)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Impotence/Sexual Dysfun.	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Jaw Pain, TMJ	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Heart Problem
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Tremors	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pain w/Cough/Sneeze	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Menopausal Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Foot or Knee Problems	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Menstrual Problem	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sinus/Drainage Problem	<input type="checkbox"/> Depression	<input type="checkbox"/> PMS	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Numb/Tingling arms, hands, fingers		<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Numb/Tingling legs, feet, toes		<input type="checkbox"/> Allergies	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Hepatitis (A,B,C)

PATIENT'S NAME: _____ HR#: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

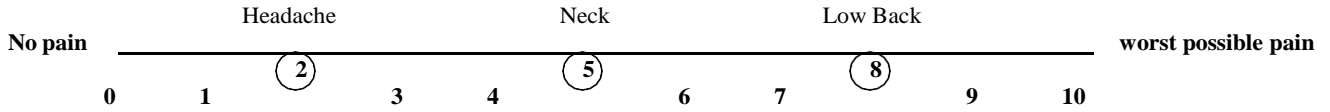
Date _____

Please read carefully:

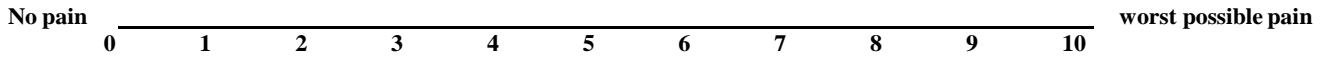
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

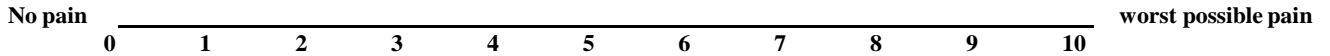
Example:



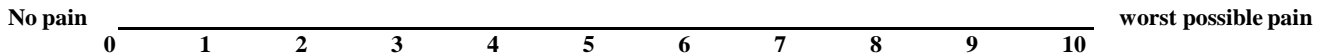
1 – What is your pain RIGHT NOW?



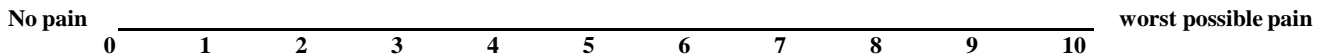
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT NAME: _____

HR# _____

DATE: _____

We are about life and health transformations in this office. If we find that you are a good fit for our protocols, we want to be able to help you to the best of our abilities. Please answer the following questions thoughtfully and honestly.

LIFE GOALS

What are your top life goals that you want to achieve in the next 5-10 years? Health related, financially, travel, family, etc.

“Think big, dream big, believe big and the results will be big!”

-
-
-
-
-
-
-
-
-

YOUR WHY

Why is it so important for you to be healthy right now?

- I want to improve my performance at work.
- I want to improve the quality of my relationships.
- I would love to enjoy life more.
- I want to have energy to do things that bring me joy.
- I want to be my best years from now.
- I want to feel better about myself.
- I want to prevent disease.
- I want to be here to see my grandkids.
- I want to start a family.
- I want to enjoy my retirement.
- I want to stop being impatient with my family.
- Other (please describe): _____

FUTURE HEALTH GOALS

On a scale of 1 to 10 (1=low, 10=high), how healthy do you feel right now? _____

My greatest health challenge right now is: _____

How would life be different if you didn't have this health challenge? _____

On a scale of 1 to 10 (1=low, 10=high), how committed are you to doing EVERYTHING possible to overcome this health challenge? _____

What obstacles do you see, right now, holding you back from getting healthy? _____