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APPLICATION FOR CARE

Date: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Occupation: _____ # of Children: _____ Spouse's Name: _____

Name & Number of Emergency Contact: _____

Relationship: _____ Do you have insurance? [] Yes [] No

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of 1 to 10 (zero = no pain; 10 = worst pain)

- 1. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
2. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
3. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10
4. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? _____

When is the problem at its worst? [] early AM [] mid-morning [] mid-day [] early evening [] late evening

How long does it last? [] constant throughout day [] I experience it on and off during the day

[] it comes and goes throughout the week

How did the injury happen? _____

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

Has the condition(s) ever been treated by anyone in the past? [] Yes [] No

If yes, when: _____ and by whom? _____

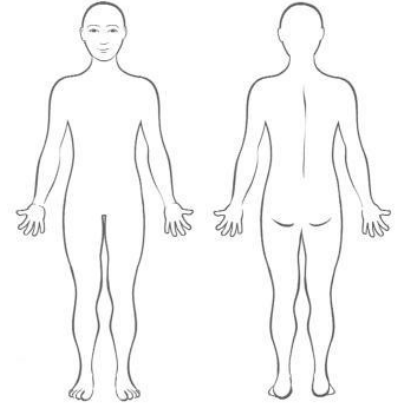
How long were you under care: _____ What were the results: _____

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
T = Tingling

A = Aching
N = Numbness
S = Sharp/Stabbing



What relieves your symptoms? _____

What makes them feel worse? _____



Please list any restricted activities, your current activity level, and your usual activity level:

RESTRICTED ACTIVITY

ex: walking _____

CURRENT ACTIVITY LEVEL

ex: walk half mile 2x/week _____

USUAL ACTIVITY LEVEL

ex: walk one mile 4x/week _____

Identify any other injuries to your spine, minor or major, that the doctor should know about: _____

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently taking: _____

Females: Is there **any chance** that you are pregnant? Yes No

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? Yes No

If yes, how many times? _____ When was the last episode? _____

How did the injury happen? _____

Have you tried any other forms of treatment: Yes No

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, activities, or events you have experienced 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:

P = in the **Past**

C = **Currently**

N = **Never** have had:

___ broken bone

___ disability

___ cancer

___ rheumatoid arthritis

___ osteoarthritis

___ diabetes

___ cerebrovascular

___ heart attack

___ dislocations

___ tumors

___ thyroid disorder

___ other: _____

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

	Condition	How Long Ago	Type of Care Received	By Whom
INJURIES				
SURGERIES				
CHILDHOOD DISEASES				
ADULT DISEASES				

SOCIAL HISTORY

1. Smoking: cigars pipe cigarettes daily weekends occasionally never

2. Alcoholic beverage consumption: daily weekends occasionally never

3. Recreational drug use: daily weekends occasionally never

4. Hobbies/recreational activities/exercise/sports: _____

FAMILY HISTORY

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

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

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

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

QUADRUPLE VISUAL ANALOGUE SCALE

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 source for each complaint (see example below).

Example:

No pain 0 1 *Headache* 2 3 4 *Neck* 5 6 7 *Low Back* 8 9 10 Worst Possible Pain

1. What is your pain level **right now**?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

2. What is your **typical** or **average** level of pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

3. What is your pain level **at its best** (how close to “0” does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

4. What is your pain level **at its worst** (how close to “10” does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Other Comments: _____

OATS Score: _____ %

ACTIVITIES OF DAILY LIVING

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life.

Reading/Concentrating	<input type="checkbox"/> N/A	<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"/> N/A	<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"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> N/A	<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"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Taking out Garbage	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying (groceries, children, etc.)	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting (groceries, children, etc.)	<input type="checkbox"/> N/A	<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"/> N/A	<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"/> N/A	<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"/> N/A	<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"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> N/A	<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 Position	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Stand to Sit Position	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> N/A	<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"/> N/A	<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"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
<i>Other:</i>	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
	<input type="checkbox"/> N/A	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please mark the listed items below as: **P** (Past) **C** (Currently) **N** (Never)

- | | | |
|------------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> headache | <input type="checkbox"/> convulsions/epilepsy | <input type="checkbox"/> diarrhea/constipation |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> tremors | <input type="checkbox"/> kidney trouble |
| <input type="checkbox"/> jaw pain, TMJ | <input type="checkbox"/> dizziness | <input type="checkbox"/> gallbladder trouble |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> loss of balance | <input type="checkbox"/> liver trouble |
| <input type="checkbox"/> upper back pain | <input type="checkbox"/> fainting | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> double vision | <input type="checkbox"/> impotence |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> blurred vision | <input type="checkbox"/> menstrual problems |
| <input type="checkbox"/> hip pain | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> PMS |
| <input type="checkbox"/> back curvature/scoliosis | <input type="checkbox"/> hearing loss | <input type="checkbox"/> menopausal problems |
| <input type="checkbox"/> numb/tingling arms | <input type="checkbox"/> asthma | <input type="checkbox"/> depression |
| <input type="checkbox"/> numb/tingling hands/fingers | <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> irritable |
| <input type="checkbox"/> numb/tingling legs | <input type="checkbox"/> lung problems | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> numb/tingling feet/toes | <input type="checkbox"/> heart problems | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> knee problems | <input type="checkbox"/> heartburn | <input type="checkbox"/> mood changes |
| <input type="checkbox"/> foot problems | <input type="checkbox"/> chest pain | <input type="checkbox"/> learning disability |
| <input type="checkbox"/> swollen/painful joints | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> low blood pressure | <input type="checkbox"/> eating disorder |
| <input type="checkbox"/> pain w/ cough/sneeze | <input type="checkbox"/> ulcers | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> allergies | <input type="checkbox"/> digestive problems | <input type="checkbox"/> Hepatitis (A, B, C) |
| <input type="checkbox"/> sinus/drainage problem | <input type="checkbox"/> colon trouble | <input type="checkbox"/> other: _____ |

I hereby authorize payment to be made directly to Risoldi Family Chiropractic 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 affecting 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 Risoldi Family Chiropractic for any and all services I receive at this office that are not covered under a healthcare plan.

Signature of Patient or Authorized Person

Date

Signature of Doctor

Date

Notes: _____

