

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

APPLICATION FOR CARE AT Rhode 2 Wellness Family Chiropractic

Today's Date: _____

HRN: _____

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

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

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

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: Primarily: _____

Secondarily: _____ 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 complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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

Fourth complaint: : 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? _____

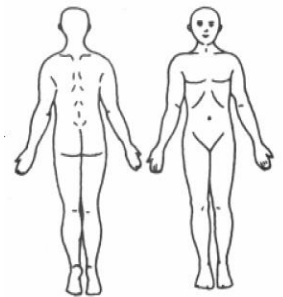
Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

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 them feel worse? _____

LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

Four sets of horizontal dashed lines for listing restricted activity, current activity level, and 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 ⑦ 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 and **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	⑦		
SURGERIES	⑦		
CHILDHOOD DISEASES	⑦		
ADULT DISEASES	⑦		

SOCIAL HISTORY

1. **Smoking:** → cigars → pipe → cigarettes ⑦ How often? → Daily → Weekends → Occasionally → Never

2. **Alcoholic Beverage:** consumption occurs ⑦ → Daily → Weekends → Occasionally → Never

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

4. **Hobbies -Recreational Activities-Exercise Regime:** How does your present problem affect the following, See pg 2- Activities of Life

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 Rhode 2 Wellness 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 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 Rhode 2 Wellness Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

_____-_____-_____
Date Completed

Doctor's Signature

_____-_____-_____
Date Form Reviewed

Patient's Name: _____

Date ___/___/___

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Please mark any other symptoms you have experienced marking the following:

P for in the ***Past***, **C** for ***Currently have*** and **N** for ***Never have had***

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

List any other medical/psychiatric conditions that have been previously diagnosed:

List any previous surgeries or other major medical procedures you have had :

List Prescription & Non-Prescription drugs you take & How long you have been taking them:

Patient's Name: _____

Date ___/___/___

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Activities of Daily Living

Daily Activities: Effects of Current conditions On Performance

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

Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Patient's Name: _____

Date ___/___/___

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INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures? _____

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field _____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident _____

Work around the house – lifting, bending, woke up with stiff neck, “back went out” _____

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? _____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _____

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

Patient's Name: _____ Date ___/___/___ JDD,DC 5/2021

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular ___Hours ___Days/Wk

Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____What is your current weight? _____

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have a damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Doctor Signature _____ Date _____ JDD, DC 5/2021