APPLICATION FOR CARE AT WIEDNER FAMILY CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

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: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined
☐ Unknown/Unavailable

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined
☐ Unknown/Unavailable

Employment Status: ☐ **Active Duty Military** ☐ **Employed Full Time** ☐ **Employed Part Time** ☐ **Not Employed**
☐ **Full Time Student** ☐ **Part Time Student** ☐ **Retired** ☐ **Self Employed** ☐ **Child**
☐ **Disabled** ☐ **Homemaker** ☐ **Other**

DO YOU HAVE A PACEMAKER OR DEFIBRILATOR? ☐ YES ☐ NO

Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Date of Birth _____

Name of Emergency Contact: _____ **Relationship:** _____

Phone Number: _____

How did you hear about our office? _____

Height? _____ Weight? _____

Do you live in Florida... ☐ Full Time ☐ Part Time

If you only live in Florida Part Time, please provide your Northern Address below:

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

CHIEF COMPLAINT

Please identify the **PRIMARY (main)** condition that brought you to this office:
Complaint 1:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT COMPLAINT 1 ONLY

Came on ☐ Gradually? ☐ Immediately?

When did your symptoms start? (When did you first feel the pain, numbness, etc)

_____

What do you think caused your symptoms?_____

_____

_____

Intensity of pain: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

Frequency: ☐Intermittent ☐ Occasional ☐ Frequent ☐ Constant

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

What relieves (improves) your symptoms?_____

Is the problem: ☐ Getting better ☐ Staying the same ☐ Getting worse

Is the problem the result of ANY type of accident? ☐ Yes ☐ No
If yes,
explain:_____

Condition ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____

by whom? _____

Length of time under care: _____

What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

DESCRIPTION OF PAIN: Circle the feeling that best describes your complaint(s):

Radiating Burning Dull Aching Numbness Sharp/Stabbing Tingling

Other
(Explain)_____

Complaint 1 Radiates
To:_____

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:

Headache Neck Low Back

No pain — 0 1 (2) 3 4 (5) 6 7 (8) 9 10 — **worst possible pain**

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1 – What is your pain 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 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:

% of time patient experiences the "worst" pain level

_____

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.

Using the table below, circle which Activities that Complaint 1 makes challenging. <u>Circle the pain level attributed to these actions</u>. (1 = very little discomfort; 10 = intolerable discomfort)

ACTIVITY (Circle 2)	MILD			MODERATE			SEVERE			
Turn head	1	2	3	4	5	6	7	8	9	10
Work at Computer	1	2	3	4	5	6	7	8	9	10
Lift	1	2	3	4	5	6	7	8	9	10
Drive	1	2	3	4	5	6	7	8	9	10
Standing	1	2	3	4	5	6	7	8	9	10
Sitting	1	2	3	4	5	6	7	8	9	10
Walking	1	2	3	4	5	6	7	8	9	10
Reaching	1	2	3	4	5	6	7	8	9	10
Climb Stairs	1	2	3	4	5	6	7	8	9	10
Bending	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Go from sitting to standing	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

Place a check mark in the box if you take any of the following types of medication:

❑ None ❑ Antacids ❑ Antibiotics ❑ Antihistamine ❑ Anti-Inflammatory ❑ Arthritis
❑ Aspirin ❑ Birth Control ❑ Blood Pressure ❑ Bone Density ❑ Cancer ❑ Cholesterol Lowering
❑ Daily Vitamins ❑ Diabetes ❑ Digestion ❑ Heart ❑ Muscle Relaxers ❑ Over the Counter
❑ Pain Medication ❑ Steroids ❑ Thyroid ❑ Other_____

PAST HISTORY

Have you suffered with this problem in the past? ❑ No ❑ Yes **If yes** how many times? _____
When was the last episode? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** what type of treatment: _____
Who provided it: _____ When did you have this treatment? _____

What were the results? ☐ Favorable ☐ Unfavorable→ please explain.
_____ _____

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 ___Disability ___Cancer
___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral vascular ___ Osteoporosis
___ High Blood Pressure ___High Cholesterol ___ Other serious conditions:_____

Please describe these conditions, and the year they happened:_____
_____
_____

PLEASE identify ALL PAST and/or **CURRENT** conditions:

DESCRIPTION	YEAR	BY WHOM
INJURIES:		
SURGERIES:		
ADULT DISEASES:		

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

_____

Allergies to medication? ☐ Yes ☐ No **Please describe the reaction:**_____

OTHER MEDICAL PROVIDERS

Name of your Primary Care Physician_____
Primary Care Physician's address & phone number_____

OTHER MEDICAL PROVIDERS **CONDITIONS THEY MANAGE**

_____
_____

SOCIAL HISTORY

1. Do you use tobacco? ❑ Yes, presently use ❑ No, never used ❑ Quit Date:_____

If yes, how many packs per day?_____ **At what age did you start smoking?**_____ Type:_____

2. Do you use Alcohol? ❑ Yes ❑ No

If yes, ❑ Daily _____ glass(es) every day ❑ Weekends _____ glass(es) every weekend ❑ Occasionally _____glass(es) per week? _____ glass(es) per month?

3. Do you use caffeine? ❑ Yes _____ cups daily ❑ Occasionally ❑ Never

4. Do you use recreational drugs? ❑ Yes ❑ No ❑ Occasionally ❑ Never

5. Hobbies /Exercise: _____

How many days per week do you exercise?_____

FAMILY HISTORY:

Please tell us about the health of your parents, siblings and grandparents. Place an **X** in the column if it applies for that family member.

	Heart Disease	Stroke	Cancer What type?	Diabetes	Arthritis	Osteoporosis
Mother						
Father						
Brother						
Sister						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						

Are there any other hereditary conditions the doctor should be aware of ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Wiedner 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 Wiedner 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: _____ **DOB:** _____ ___/___/___ JDD,DC 5/2011

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES
FOR
WIEDNER FAMILY CHIROPRACTIC

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for appointment reminders, follow up calls, birthday greetings, etc.:

_____Mail: Address:_____
_____Email: Email address:_____@_____
_____Cell Phone: (_____)_____ _____Ok to leave detailed message
_____I agree to receive text messages on this number
_____Home Phone: (_____)_____ _____Ok to leave detailed message

By initialing the line below I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____
Patient Name (please print) Date

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

_____
Print name (if other than patient)