**Patient Name: _____ DOB: _____ Date_____**

PURE LIFE
CHIROPRACTIC

# NEW PATIENT APPLICATION

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

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

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## PATIENT DEMOGRAPHICS

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

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-mail Address: _____ Best Phone: _____

Social Security #: _____ Text OK: ☐ Yes ☐ No Carrier: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer:_____

Number of children and ages:_____

Name & Number of Emergency Contact: _____Relationship: _____

## HISTORY OF COMPLAINT

Please identify ALL 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? _____ How did it happen? _____
_____

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

How long does it last? ☐ It's constant ☐ on and off throughout the day ☐ It comes and goes throughout the week

Name all treating providers you are seeing along with the date you were last seen:

Provider: _____ Date: _____ Provider: _____ Date: _____

Provider: _____ Date: _____ Provider: _____ Date: _____

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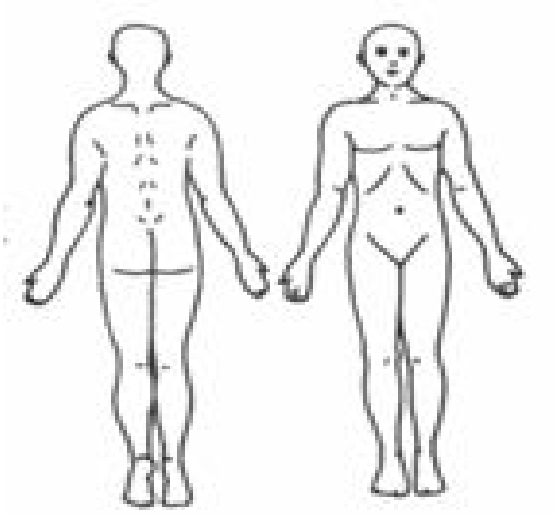
**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

**R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness
**S = S**harp/**S**tabbing **T = T**ingling



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

What relieves your symptoms?

_____

What makes your symptoms feel worse?

_____

Is your problem the result of any type of **ACCIDENT**? ☐ Yes ☐ No

Where were you when the **ACCIDENT** occured? ☐ Vehicle ☐ Work ☐ Other:

_____

Identify any other issues, minor or major:

_____

_____

**PAST HISTORY**

Have you suffered with this condition or a similar problem in the past? ☐ No ☐ Yes **If yes,** how many times?

_____

When was the last episode? _____ How did it happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what type** of treatment:

Treatment: _____ ☐ Favorable ☐ Unfavorable Treatment: _____ ☐ Favorable ☐ Unfavorable

Treatment: _____ ☐ Favorable ☐ Unfavorable Treatment: _____ ☐ Favorable ☐ Unfavorable

Unfavorable please explain: _____

_____

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

_____

_____

## 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 ☐ N/A

Condition: _____ Condition: _____ Condition: _____

## 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**: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**4. List Prescription & Non-Prescription drugs you take (include supplements):_____**

**_____**

## SYMPTOM HISTORY

Please identify any symptoms you are experiencing and indicate **C** for **CURRENT** or **P** for **PAST**

| | | | | | |
|---|---|---|---|---|---|
| Headache | Jaw Pain/TMJD | Neck Pain | Shoulder Pain | Upper Back Pain | Mid Back Pain |
| Lower Back Pain | Hip Pain | Back curvature/ Scoliosis | Numb/tingling arms | Numb/tingling legs | Foot/knee problems |
| Mood changes/ irritable | Depression | Learning Disability | ADD/ADHD | Loss of Balance | Fainting |
| Dizziness | Seizures/ Epilepsy | Tremors | Ringing in Ears | Hearing Loss | Double/Blurred Vision |
| Frequent Colds/Flu | Sinus Problems | Allergies | High/Low BP | Heart Problem | Chest Pain |
| Lung Problems | Asthma | Difficulty Breathing | Heartburn | Ulcers | Eating Disorder |
| Diabetes/ | Liver trouble | Hepatitis | Gall Bladder | Kidney Trouble | Colon Trouble |

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| | | | | | |
|---|---|---|---|---|---|
| Hypoglycemia | | | Trouble | | |
| Diarrhea | Constipation | Menopause issues | Menstrual problems | Bed Wetting | Pain w/Cough or sneeze |
| Impotence | Sexual dysfunction | Prostate problems | Trouble sleeping | Cancer | Osteoporosis |

**QUADRUPLE VISUAL ANALOGUE SCALE**

Instructions: Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint.

**Example:**

Complaint 1 Complaint 2 Complaint 3

No pain Worst Possible Pain

0 1 ② 3 4 ⑤ 6 7 ⑧ 9 10

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1. What is your pain **RIGHT NOW**? *Please identify EVERY symptom SEPARATELY*

No pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain? *Please identify EVERY symptom SEPARATELY*

No pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST**? *Please identify EVERY symptom SEPARATELY*

No pain Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST**? *Please identify EVERY symptom SEPARATELY*

No pain Worst Possible Pain

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_____

0 1 2 3 4 5 6 7 8 9 10

**5. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following? Please **CIRCLE** the activities you would like to improve as part of your goals for care in our office.

| **ACTIVITY** | **EFFECT** | | | |
|---|---|---|---|---|
| | No Effect | Painful (can still do) | Painful (limits) | Unable to Perform |
| Lift Children/Groceries | | | | |
| Read/Concentrate | | | | |
| Getting Dressed | | | | |
| Washing/Bathing | | | | |
| Intimate Activities | | | | |
| Sleep | | | | |
| Static Sitting | | | | |
| Static Standing | | | | |
| Walking | | | | |
| Sweeping/Vacuuming | | | | |
| Dishes | | | | |
| Cooking | | | | |
| Laundry | | | | |
| Garbage | | | | |
| Driving | | | | |
| Yard work | | | | |
| Sports | | | | |

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| | | | | |
|---|---|---|---|---|
| Other: _____ | | | | |