APPLICATION FOR CARE AT DRAAYER CHIROPRACTIC CLINIC

Today's Date: _____ ***Whom may we thank for referring you to this office?*** _____

PATIENT DEMOGRAPHICS

Please present your insurance card and photo ID to the front desk for copies

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

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

Home Phone: _____ Mobile Phone:_____ Work Phone: _____

Email Address: _____ Preferred Method of Contact: ☑ HOME ☐ CELL ☐ WORK ☐ EMAIL

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Children's Names 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

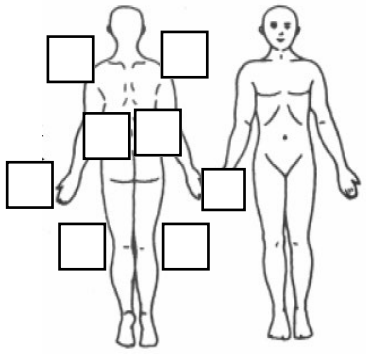
How did the injury happen? _____

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 = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

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:

_____

_____

Please list any medications you are currently taking (including OTC, herbal, enzymes, natural supplements, etc): _____
_____
_____

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 leave blank if they don't apply to you**:**

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

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 →			

Anything else you feel the doctor should know about your condition? _____
_____

SOCIAL HISTORY

1. Nicotine: ☐cigars ☐ pipe ☐ cigarettes ☐ chew ☐ vape How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

What is the major stressor in your life? _____
In addition to the main reason for your visit today, what additional health goals do you have? _____
_____

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: _____

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