APPLICATION FOR CARE AT TILTON CHIROPRACTIC & WELLNESS CENTER

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

PATIENT DEMOGRAPHICS

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

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

Email: _____ Home Phone: _____ Mobile Phone: _____

Driver's License #: _____ Work Phone: _____

Marital Status: ☐ Single ☐ Married Do you have insurance?: ☐ Yes ☐ No

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:

Primary: _____ Secondary: _____

Third: _____ Fourth: _____

On a scale of 1 to 10, with 10 being the worst pain and 0 being no pain, rate your 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 ☐ I experience is on/off all day ☐ 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: _____

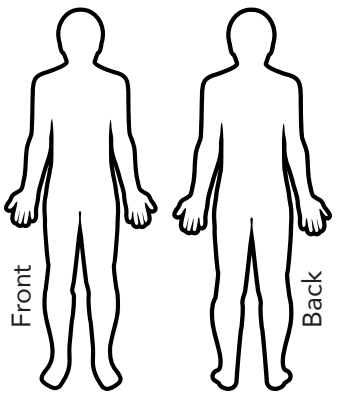
Name of previous Chiropractor: _____ ☐ N/A

PLEASE MARK THE DIAGRAM

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: _____

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 --> 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:

By Whom	How Long Ago	Type of Care Received
Injuries		
Surgeries		
Childhood Diseases		
Adult Diseases		

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: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies/Recreational Activities/Exercise Regime: How does your present problem affect the following, See pg 2
5. Nutrition: How many glasses of water/day: _____ Caffeinated drinks/day: _____ Veggies/day: _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes If yes, who:
   ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)
2. Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know
3. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Tilton 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 Tilton 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: _____

PLEASE MARK 'P' FOR IN THE PAST, 'C' FOR CURRENTLY HAVE & 'N' FOR NEVER

___ Headache
___ Pregnant (Now)
___ Dizziness
___ Prostate
___ Ulcers
___ Neck Pain
___ Frequent Colds
___ Flu
___ Loss of Balance
___ Impotence
___ Sexual Dysfun
___ Heartburn
___ Jaw Pain, TMJ
___ Convulsions
___ Epilepsy
___ Fainting

___ Digestive
___ 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
___ Pain w/ Sneeze

___ Ringing in Ears
___ Menopausal
___ Asthma
___ Low Back Pain
___ Foot/Knee Trouble
___ Hearing Loss
___ Menstrual
___ Difficulty Breathing
___ Hip Pain
___ Sinus/Drainage
___ Depression
___ PMS
___ Lung Problems
___ Back Curvature
___ Swollen Joints
___ Irritable

___ Bed Wetting
___ Kidney Trouble
___ Scoliosis
___ Skin Problems
___ Mood Swing
___ Learning Trouble
___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers
___ ADD/ADHD
___ Eating Trouble
___ Liver Trouble
___ Numb/Tingling legs, feet, toes
___ Allergies
___ Trouble Sleeping
___ Hepatitis (A, B, C)

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____

_____

_____

_____

ACTIVITIES OF DAILY LIVING/SYMPTOMS/MEDICATIONS

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
Recreational 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

INITIAL NERVE SYSTEM PROFILE

Patient Name _____ Date _____

What 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 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" _____

Doctor Signature _____ Date _____

TILTON Chiropractic