

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

APPLICATION FOR CARE AT EAST VALLEY CHIROPRACTIC

Today's Date: _____

HRN: _____

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: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

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 = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

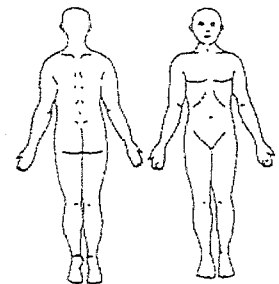
What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Who is your Primary Care Physician? _____ Their Location _____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

LIFESTYLE CHOICES SELF EVALUATION



Please rate the following on a 1-10 scale with 10 being perfect and 0 being extremely poor.

Exercise ____/10

Diet ____/10

Water Intake ____/10

Sleep ____/10

Stress Management ____/10

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 **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			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			
MEDICATIONS			

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? (See ADL form)

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 East Valley 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 East Valley Chiropractic for any and all services I receive at this office. I agree to have a card on file to pay for any of the services that I receive by East Valley Chiropractic. I will have a card on file unless otherwise discussed with Dr. Ty and have a signed agreement for the other payment option.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

Functional Rating Index

For use with Neck and/or Back problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, please circle the one choice with most closely describes your condition right now.

1. Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
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6. Recreation

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain
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2. Sleeping

Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed sleep	Greatly disturbed sleep	Totally Disturbed Sleep
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7. Frequency of Pain

No pain	Occasional Pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day
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3. Personal care (washing, dressing, etc.)

Pain restrictions	Mild Pain No restrictions	Moderate Pain; need to go slowly	Moderate Pain; need some assistance	Severe Pain; need 100% assistance
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8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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4. Travel (driving, etc)

No Pain On long trips	Mild Pain on long trips	Moderate Pain; on short trips	Severe pain on short trips
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9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ miles	Increased pain after ¼ miles	Increased pain with all walking
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5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% usual work	Can do 25% usual work	Cannot Work
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10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing
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Signature X _____ Printed Name _____ Date ____/____/____

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please review the below listed symptoms and conditions and indicate those that are current health problems of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

[illegible]