Welcome to our Wellness Center.

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

APPLICATION FOR CARE AT AYS CHIROPRACTIC Louisville

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: ___o Male o Female

Address: _____City: _____State: _____ Zip: _____

E-mail Address: _____Home Phone: _____Mobile:_____

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: _____

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? o AM o PM o mid-day o 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

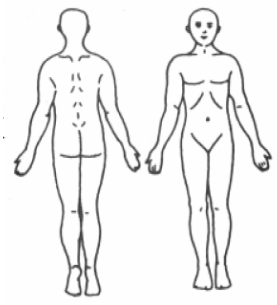
How did the injury happen? _____

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? _____

LIST RESTRICTED ACTIVITY: **CURRENT ACTIVITY LEVEL** **USUAL ACTIVITY LEVEL**

_____: _____

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

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

_____

_____

On a scale of 1 – 10, rate the importance for you to achieve the following: 1 = not important 10 = necessary

Get fit 1 2 3 4 5 6 7 8 9 10

Eat better 1 2 3 4 5 6 7 8 9 10

Reduce stress 1 2 3 4 5 6 7 8 9 10

Stop smoking 1 2 3 4 5 6 7 8 9 10

Reduce pain 1 2 3 4 5 6 7 8 9 10

Increase my mobility 1 2 3 4 5 6 7 8 9 10

Improve my posture 1 2 3 4 5 6 7 8 9 10

Learn about wellness 1 2 3 4 5 6 7 8 9 10

Learn about wellness products that are right for me 1 2 3 4 5 6 7 8 9 10

Which of the above would you say is the most important goal for you to achieve and why?

_____

_____

Have you ever attempted to accomplish this goal in the past? Yes No

If yes, what happened and what prevented you from maintaining your results? _____

_____

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 injury happen?_____

Other forms of treatment tried: o No o Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. o Favorable o 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**:**

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			

ADULT DISEASES →

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer___ Heart Attack OsteoArthritis ___ Diabetes ___Cerebral Vascular___ Other serious conditions: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

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 Align Your Spine Chiropractic Louisville, LLC, 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 Align Your Spine Chiropractic Louisville, LLC for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

We welcome you to the world of wellness. Remember, your health is your greatest asset, the more of it you have the healthier you are.