How did you hear about our office? → _____

APPLICATION FOR CARE AT REVOLUTION CHIROPRACTIC

Today's Date: _____ VRC: _____

PATIENT DEMOGRAPHICS

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

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

E-mail Address: _____

Phone Numbers → Mobil: _____ Home: _____

Marital Status: ❑ Single ❑ Married ❑ Other _____ Do you have Insurance: ❑ Yes ❑ No

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

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of Children & Ages: _____

Emergency Contact → Name: _____ #: _____ 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 c*ircling the number.*

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaints is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint: : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint: : 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

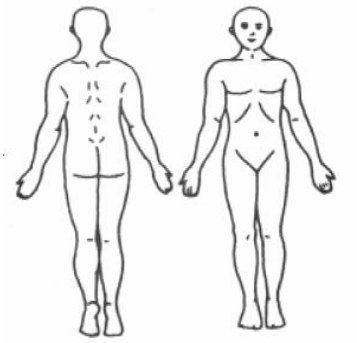
How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ on and off throughout the week

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes → If yes, when: _____

Have you been to a chiropractor in the past? ☐ Yes or ☐ No

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

A = **A**ching **B** = **B**urning **C** = **C**old **D** = **D**ull
N = Numb **P** = **P**ulsing/throbbing **R** = **R**adiating
S = **S**harp/Stabbing **T**= Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

ACTIVITIES OF DAILY LIVING

Circle the number that most accurately depicts how your daily activities are impacted.
(ZERO) No Effect → Painful (can do) → Painful (limited) → Unable to Perform (FIVE)

Concentrating	0 - 1 – 2 – 3 – 4 – 5	Sitting	0 - 1 – 2 – 3 – 4 – 5
Computer Work	0 - 1 – 2 – 3 – 4 – 5	Standing	0 - 1 – 2 – 3 – 4 – 5
Sports / Recreation	0 - 1 – 2 – 3 – 4 – 5	Sitting ↔ Standing	0 - 1 – 2 – 3 – 4 – 5
Sleeping	0 - 1 – 2 – 3 – 4 – 5	Working	0 - 1 – 2 – 3 – 4 – 5
Watching TV	0 - 1 – 2 – 3 – 4 – 5	Doing Chores	0 - 1 – 2 – 3 – 4 – 5
Carrying/Lifting	0 - 1 – 2 – 3 – 4 – 5	Driving	0 - 1 – 2 – 3 – 4 – 5
Bending	0 - 1 – 2 – 3 – 4 – 5	Sexual Activity	0 - 1 – 2 – 3 – 4 – 5
Dressing	0 - 1 – 2 – 3 – 4 – 5	Reading	0 - 1 – 2 – 3 – 4 – 5
Pushing	0 - 1 – 2 – 3 – 4 – 5	Running	0 - 1 – 2 – 3 – 4 – 5
Rolling Over	0 - 1 – 2 – 3 – 4 – 5	Walking	0 - 1 – 2 – 3 – 4 – 5

What is your current activity level & frequency? (ie: gym, running, walking, yoga etc)

_____

_____

ACCIDENT HISTORY

Have you ever been involved in ANY type of fall or car accident? ☐ Yes, ☐ No

Explain any/all injury(s), minor or major: (ie: car accidents, falls, sports injuries etc)

_____

_____

_____

MEDICAL HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes

Other forms of treatment tried (ie. PT, acupuncture, massage, medications, injections): ☐ No ☐ Yes

If yes, please state **what** type of treatment: _____

What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

Please identify any/all types of jobs you have had in the past that have imposed any physical stress on you/your body:
(ie: sitting/standing/lifting etc)

_____

If you have ever been diagnosed with any of the following conditions, write the appropriate letter
P for in the **Past**, **C** for **Currently** have, and **N** for **Never** have had:

___ Broken Bone ___Dislocations ___ Tumors ___ Arthritis ___ Digestive Issues ___Disability ___Cancer
___ Heart Attack ___Thyroid Issues ___ Diabetes ___Cerebral Vascular ___ Other: _____

PLEASE identify ALL PAST and any CURRENT conditions - even if they seem unrelated

	HOW LONG AGO	TYPE OF CARE RECEIVED
INJURIES (if not listed above) →		
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

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
   If yes whom: ❑ grandparent ❑ Parent ❑ Sibling ❑ Child ❑ Other: _____
   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: _____

MEDICATIONS

List Prescription & Non-Prescription drugs you take & What they are for: _____

_____

_____

_____

I hereby authorize payment to be made directly to Revolution 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 Revolution 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

REVOLUTION CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Revolution Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant. I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays.

REGARDING: X-rays/Imaging Studies

By my signature below I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date