PERFORMANCE
CHIROPRACTIC & SPORTS MEDICINE

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

APPLICATION FOR CARE

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: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ 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 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 **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

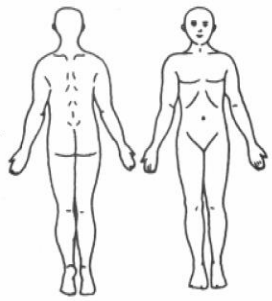
How did the injury happen?_____

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 them feel worse? _____

Please List Any Medications You Are Taking: **Reason You Are Taking It/Why It Was Prescribed**

_____: _____

_____: _____

_____: _____

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 *N**ever** 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 →			

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

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 Performance Chiropractic & Sports Medicine, 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 Performance Chiropractic & Sports Medicine 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: _____ HR#: _____ ___/___/___ JDD,DC 5/2011

PERFORMANCE
CHIROPRACTIC & SPORTS MEDICINE

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ File#_____
Date: _____

Daily Activities: Effects of Current Conditions On Performance

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
Recreation 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

Review of Systems

GENERAL APPEARANCE
□ Weight Loss □ Weight Gain □ Change in Sleeping Patterns □ Change in Activity Capacity

NEUROLOGICAL
□ Anxiety □ Headaches □ Depression □ Meningitis □ Paralysis □ Seizure □ Stroke □ Tingling □Tremors □ Memory Loss □ Fainting spells □ Dizziness □ Head injuries □ Blackouts or near blackouts □ Change in sensation anywhere on your body □ Localized weakness or numbness

EARS, EYES, NOSE, & THROAT
□ Hay fever □ Glaucoma □ Polyps □ Allergy □ Cataracts □ Goiter □ Hoarseness □ Double vision □ Gum problems □ Eye problems □ Ear Infections □ Glasses/contacts □ Hearing Loss □ Ear discharge/pain □ Frequent nosebleeds □ Ringing in your ears □ Sinus infections □ Swollen glands

CARDIOVASCULAR
□ Angina □ Leg cramps □ Ankle swelling □ Awakening at night short of breath & getting out of bed □ Cardiac catheterization □ Cold hands or feet □ Congenital heart defects □ Dizziness when standing up quickly □ Heart attacks □ Heart failure □ High or low blood pressure □ Irregular heart rate □ Purple fingers or lips □ Leg pain that resolves with rest □ Heart palpitations □ Varicose veins □ Chest pains □ Murmurs

RESPIRATORY
□ Asthma □ Breathlessness when lying flat □ Prolonged cough □ Coughing up blood □ Emphysema □ Shortness of breath □ Tuberculosis □ Pneumonia
□ Frequent infections (bronchitis) □ Wheezing □ Pleurisy

SKIN
□ Abscess □ Dandruff □ Acne □ Oily skin □ Boils □ Rashes □ Hives □ Dry skin □ Lumps □ Psoriasis □ Jaundice □ Athlete's foot □ Excessive body odor □ Excessive sweating □ Fungal infections □ Nail problems □ Moles- irregular □ Moles - change/new

KIDNEYS & URINARY TRACT
□ Blood in urine □ Brown urine □ Dribbling after urination □ Painful urination □ Excessive thirst □ Involuntary urination/incontinence □ Urinating frequently (day) □ Urinating frequently (night) □ Urine hesitancy □ Weak flow □ Frequent bladder infections □ Kidney disease □ Kidney stone

ENDOCINE
□ Diabetes □ Sickle cell □ Abnormal body hair □ Changes in skin texture □ Cold intolerance □ Heat intolerance □ History of "borderline" diabetes

MUSCULOSKELETAL
□ Anemia □ Arthritis □ Back pain □ Bursitis □ Gout □ Joint aches □ Neck pain □ Tendinitis □ Abnormal Blood Counts □ Blood clots in legs/lungs □ Bone Marrow Biopsy □ Easy Bleeding □ Easy bruising □ Joint swelling □ Morning stiffness □ Muscle aches

GASTROINTESTINAL
□ Diarrhea □ Reflux □ Ulcers □ Hepatitis □ Abdominal pain □ Anal fissures □ Black tarry stools □ Vomiting blood □ Constipation □ Nausea □ Problems swallowing □ Hiatal Hernia □ Intestinal obstruction □ Liver disease □ Hemorrhoids □ Red blood after bowel movements □ Gallstones □ Vomiting □ Heartburn □ Indigestion

MALE & FEMALE
□ Painful sexual intercourse □ Loss of sexual interest □ Unprotected sex □ Groin itching □ Sexually transmitted diseases

MALES ONLY
□ Hernia □ Sterility □ Bloody ejaculation □ Inability to complete intercourse □ Lump on testicle □ Penile discharge □ Problems maintaining or keeping an erection □ Prostate disease □ Sores on penis or warts □ Testicular pain □ Testicular swelling

FEMALES ONLY
□ D & C □ Hot flashes □ Hernia □ Fibroids □ Abnormal bleeding between cycles □ Abnormal pap smear □ Bleeding after intercourse □ Complications w/ pregnancy □ PMS □ Endometriosis □ Heavy bleeding during cycles □ Discharge from breast □ Ovarian cysts □ Pelvic Inflammatory Disease □ Postmenopausal symptoms □ Vaginal discharge □ Vaginal Dryness □ Vaginal warts

Not Listed Above:_____

_____

,DC 5/2011

PERFORMANCE
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Patient Name_____ File#/HRN _____Date_____

INITIAL NERVE SYSTEM PROFILE

When 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 the 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** _____, DC 5/2011