MOMENTUM
CHIROPRACTIC

# APPLICATION FOR CARE AT MOMENTUM CHIROPRACTIC

***Please Fill Out Form Completely, If a Question Does Not Apply, Mark N/A***

Today's Date: _____

## PATIENT DEMOGRAPHICS

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

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Last 4 digits of S.S. #: _____ Driver's License # _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

How did you hear about our office?

☐Google ☐Facebook ☐Instagram ☐Nextdoor

☐Referral (please name) _____ ☐Our website

## HISTORY of COMPLAINT

Please list the condition(s) that brought you into the 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) start? _____ 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 occur? _____

Have you seen anyone else for these condition(s) in the past? ☐No ☐ Yes **If yes,** when: _____

by whom? _____

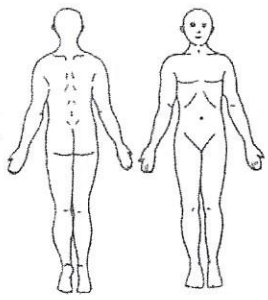
How long were you under care: _____ What were the results? _____

Have you ever been to a Chiropractor: _____ ☐ **yes (who?)** ☐ **no**

Are you currently taking any medications? (if so, please list) _____

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

**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What makes the symptoms feel better? _____

What makes the problem feel worse? _____

Does the problem change in sensation (ex: numbness that turns to burning)?

_____

| ACTIVITY RESTRICTIONS: | CURRENT ACTIVITY LEVEL: | USUAL ACTIVITY LEVEL: |
|---|---|---|
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |

Are any of your above complaints the result of an accident or trauma? ☐ Yes, ☐ No
If Yes, briefly describe the incident: _____

Identify any injury(s) to areas of the spine, surgical or non-surgical, that our office should be aware of:

_____

_____

**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 occur? _____

Have you tried other treatment options?: ☐ No ☐ Yes **If yes,** please state **what** type of treatment **and** the provider:

_____

**How long ago?** _____What were the results? ☐ Resolved ☐ Unresolved ☐ Unable to determine

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 ___Osteoarthritis ___ Diabetes ___Cerebral Vascular ___ Disc Problems
___Other ___Multiple Sclerosis

**PLEASE identify ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:
Childhood conditions: _____
Adult conditions/diagnoses: _____

**DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS**? (if so, please list)
_____

**VERIFICATION QUESTION (*please circle the question you've chosen and provide the answer. This will further protect your files within our clinic)***

☐What is your mother's maiden name? ☐What is your favorite place you've visited?
☐What elementary school did you attend? ☐What city were you born in?
☐What is your favorite movie? ☐What is your father's middle name?
***Answer to verification question:*** _____

**SOCIAL HISTORY & HABITS**

**1. Smoking**: ☐cigars ☐ pipe ☐ cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
**2. Alcoholic Beverage**: ☐ 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:** ☐ 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 Momentum Chiropractic 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 Momentum Chiropractic LLC for any and all services I receive at this office.

_____

**Patient or Authorized Person's Signature**

_____ - _____ - _____

**Date Completed**

_____

**Doctor's Signature**

_____ - _____ - _____

**Date Form Approved For Care**