APPLICATION FOR CARE AT WELLSVILLE CHIROPRACTIC, LLC.

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ Male / Female
Name you wish to be called in our office: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Social Security #: _____
Name of Spouse: _____ Spouse's Birth Date: _____
Spouse's Employer: _____ Occupation: _____
Names and Ages of your children: _____
Name & Number of Emergency Contact: _____ Relationship: _____

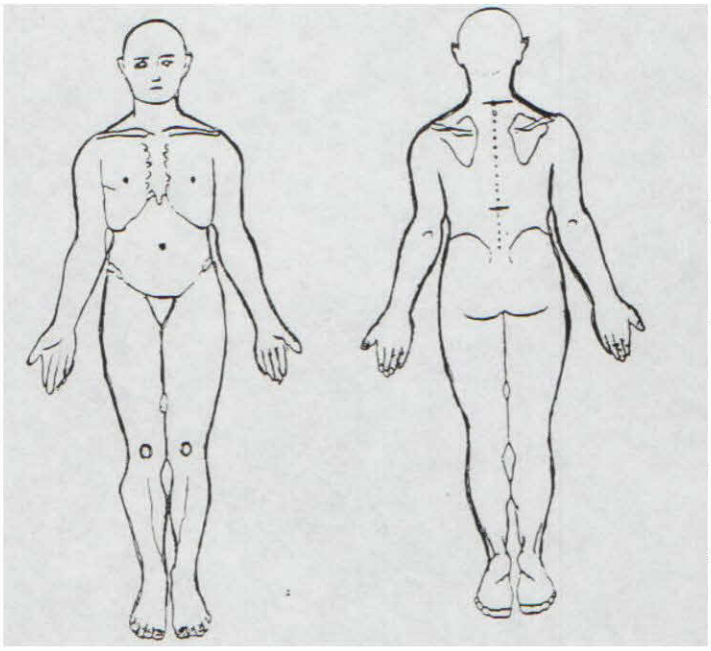
As a society we are 50th in the world in health care. We take pride in helping people to reach their optimum health and wellness. With that being said, we need an honest assessment of where you believe your current level of health is. So please place an "X" on the scale below marking where you believe your level of health and wellness is at this time. Then place a star (*) on the diagram indicting where you would like your health and wellness to be:

Very Challenged | Challenged | Transition | Good | Excellent

Premature Death — Absence of Disease
Optimal Wellness

HISTORY of COMPLAINT(s)

What brings you into our office? Below, please describe your primary and secondary problem. If you have **no** symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the next page.



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 = A**ching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Do your symptoms cause you to feel worse in the: o AM o PM o mid-day o late PM

Have these Problems ever been treated by anyone in the past?
o No o Yes
If yes, Who provided:

_____
How long ago? _____What **type** of treatment did you receive?

_____
What were the **results?** o Favorable o Unfavorable
If unfavorable please explain: _____

_____
List any **medications** taken to treat these conditions: _____
Did they help? o No o Yes If you still take them how often? _____

Have you ever been under chiropractic care? o No o Yes **If yes,** how long ago: _____
Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident**? o No o Yes
If yes, How long ago? _____ Please explain what type of accident: _____

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Curre** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___Diabetes ___ Other_____

2. PLEASE, **identify** ALL PAST **and any** unrelated current **conditions you feel may be contributing your present problem: Please include any previous childhood illnesses, adult diseases, accidents and surgeries and dates:**

_____

_____

_____

For Women Only: Are you pregnant? (circle one) Yes No

SOCIAL HISTORY

1. Smoking: o cigars o pipe o cigarettes How often? o Daily o Weekends o Occasionally o Never
2. Alcoholic Beverage: consumption occurs: o Daily o Weekends o Occasionally o Never
3. Recreational Drug use: o Daily o Weekends o Occasionally o Never
4. How many years of school have you completed? o 1-8 o 8-12 o 12-14 o 14-16 o 16 +

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? o No o Yes
If yes whom: o Grandmother o Grandfather o Mother o Father o Sister(s) o Brother(s) o Son(s) o Daughter(s)
2. Have they ever been treated for their condition? o No o Yes o I don't know
3. Any other hereditary conditions the doctor should be aware of o No o Yes _____

Whom may we thank for referring you into our office today? _____
How do you plan to take care of your charges today? o Cash o Check o Credit Card

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, a although rare, minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per two million) is a cervical spine (neck) adjustment causing injury to a vertebral arte which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature Date Completed

Reviewed by: _____ _____
Reviewer Initials Doctors Initials