

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



APPLICATION FOR CARE AT

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: _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Co: _____ ID# _____

Subscriber Name _____ Birthdate: _____

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? 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? _____

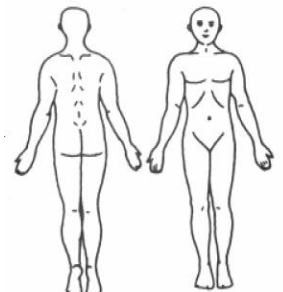
Name of Previous Chiropractor: _____ N/A

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

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/Stabbing T = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



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

LIFESTYLE CHOICES SELF EVALUATION

Please rate the following on a 1-10 scale with 10 being perfect and 0 being extremely poor.

Exercise ___/10 Diet ___/10 Water Intake ___/10 Sleep ___/10 Stress Management ___/10

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 or **N** for **Never** 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

- Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- Recreational Drug use:** Daily Weekends Occasionally Never
- Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

FAMILY HISTORY:

- 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
- Any other hereditary conditions the doctor should be aware of?** No Yes: _____

I hereby authorize payment to be made directly to [Robin Wellness Center](#), 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 [Robin Wellness Center](#) 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#: _____ Date: _____