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

# APPLICATION FOR CARE AT INNATE WAY FAMILY CHIROPRACTIC

**PATIENT DEMOGRAPHICS:**

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

Address: _____ City: _____State: _____ Zip: _____

E-mail Address: _____ Mobile Ph: _____Work Ph: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W

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

Employer: _____ Occupation: _____

Spouse's Name: _____ Spouse's Employer: _____

Name of Children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

**HISTORY of COMPLAINT:**

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Tertiary: _____ Quaternary: _____

On a scale of **0** to **10** with **10** being the worst pain and **0** 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
**Secondary** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Tertiary** complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Quaternary** 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

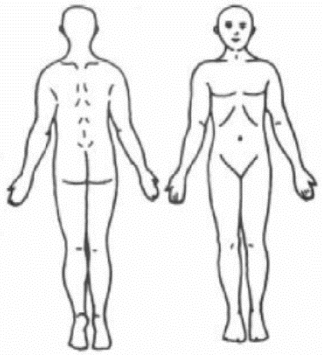
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

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

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

| **LIST RESTRICTED ACTIVITY:** | **CURRENT ACTIVITY LEVEL** | **USUAL ACTIVITY LEVEL** |
|---|---|---|
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |

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 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
if 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 and your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for **Past**, **C** for **Currently have** or leave blank if neither:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

**PLEASE identify ALL PAST** and **CURRENT** conditions, especially those you feel may be contributing to your present problem:

| | DATE | INJURY | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|---|
| **INJURIES** | → | | | |
| **SURGERIES** | → | | | |
| **CHILDHOOD DISEASES** | → | | | |
| **ADULT DISEASES** | → | | | |
| **MOTOR ACCIDENTS** | → | | | |

**SOCIAL HISTORY:**

1. **Smoking**: ☐cigarettes ☐smokeless ☐vapor ☐narcotics How often? ☐Daily ☐Weekends ☐Occasionally ☐Past
2. **Alcoholic Beverage**: consumption occurs ☐Daily ☐Weekends ☐Occasionally ☐Never
3. **Water consumption daily**: _____ ounces

**EMOTIONAL STRESSORS:**

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stress below:

| | | | | | |
|---|---|---|---|---|---|
| Childhood Trauma | ☐ Yes ☐ No | Loss of loved one | ☐ Yes ☐ No | Abuse | ☐ Yes ☐ No |
| Work or School | ☐ Yes ☐ No | Divorce/separation | ☐ Yes ☐ No | Financial | ☐ Yes ☐ No |
| Lifestyle Change | ☐ Yes ☐ No | Parents Divorce | ☐ Yes ☐ No | Illness | ☐ Yes ☐ No |

**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: _____

**QUALITY OF LIFE (presently)**

How do you grade your physical health? ☐ Good ☐ Fair ☐ Poor
How do you grade your emotional/mental health? ☐ Good ☐ Fair ☐ Poor
How do you rate your overall "quality of life"? ☐ Good ☐ Fair ☐ Poor
Do you exercise regularly? If yes, how often? _____
Do you take supplements? If yes, please list: _____
Do you follow a special dietary regime? ☐ Yes ☐ No _____

**YOUR EXPECTATIONS FROM CHIROPRACTIC CARE**

I would like to experience the following benefits from Chiropractic Care
☐ Relief of a symptom or problem
☐ Relief and Prevention of a symptom or problem
☐ Healthier spine and nerve system
☐ Optimal health on all levels
☐ Other _____

## ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

| Activities: | EFFECT: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lift Children/Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climb Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Read/Concentrate | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Getting Dressed | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Shaving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sexual Activites | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sleep | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Static Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Yard Work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Washing/Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sweeping/Vacuuming | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dishes | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Laundry | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Garbage | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

**List Prescription Drugs, Non-Prescription Drugs, and Supplements you take:** _____

_____

## REVIEW OF SYSTEMS

Please mark **P** for in the **PAST**, **C** for **Currently** have, or **leave blank** if never

| | | | | |
|---|---|---|---|---|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn |
| ___ Jaw Pain, TMJ | ___ Convulsions/Epilepsy | ___ Fainting | ___ Digestive Problems | ___ Heart Problem |
| ___ Shoulder Pain | ___ Tremors | ___ Double Vision | ___ Colon Trouble | ___ High Blood Pressure |
| ___ Upper Back Pain | ___ Chest Pain | ___ Blurred Vision | ___ Diarrhea/Constipation | ___ Low Blood Pressure |
| ___ Mid Back Pain | ___ Pain w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

## Financial Information

**PLEASE READ AND SIGN**

1. I acknowledge that Innate Way Family Chiropractic has informed me that they are not in network with any insurance providers. Therefore, they cannot guarantee that claims for any services rendered to me by Dr. Sarah Connelly and/or Innate Way Family Chiropractic will be reimbursed.
2. I consent to receive communication from Innate Way via email, postal mail, text and telephone messaging in connection with my care.
   ☐ Yes ☐ No If I should withdraw my consent, I will notify the office in writing.
3. I consent to my name (first name, last initial) being posted on the Referral Board when I refer a new patient to Innate Way.
   ☐ Yes ☐ No If I should withdraw my consent, I will notify the office in writing.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Sarah Connelly and the staff at Innate Way Family Chiropractic permission to render care to me today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

I hereby authorize payment to be made directly to Innate Way Family 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 Innate Way Family 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**