COASTAL FAMILY CHIROPRACTIC PATIENT APPLICATION

WELCOME TO OUR OFFICE – WE APPRECIATE YOUR TRUST

(Please print using BLACK or BLUE ink. If something does not apply to you please put N/A on the line.)

Section 1: Patient Information   Appt. Date: ___________   Referred By:________________

Name (first, middle, last): ____

Preferred Name: ______________________ [ ] Male [ ] Female Date of birth ___/___/______ Age _____

Address: ____ City: _____________ State: _____ Zip _________

Home Phone: (____) _____________ Cell Phone: (____) _______________ Work Phone: (____) _____________

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widow

Employer: _______________________ Occupation: ________________ E-MAIL _____________________

Name of spouse/significant other: _______________ Names/ages of children: ___________________________

Emergency Contact: _____________________ Relationship: ______________ Phone#: (____) _____________

Section 2: History of Complaint

Primary Complaint(s): ____

Secondary Complaint(s): ____

Are your complaints due to an accident? [ ] YES [ ] NO If yes, what type? [ ] Work [ ] Auto [ ] Personal

Date of Accident__________ If Work or Auto accident, have you reported this accident to anyone? [ ] YES [ ] NO

Who was it reported To? ____________________ Have you seen any doctors for this condition: [ ] YES [ ] NO

Please list the doctor specialty, & for how long you were seen : ____

____

Emergency List any medications you currently take. (Prescription and non-prescription): ____________________

____

____

Section 3: Family History:

Does anyone in your family suffer with the same condition(s) or other chronic illnesses? [ ] YES [ ] NO

If yes whom & what condition(s):____

____

Section 4: Chiropractic History:

Have you ever seen a chiropractor before? [ ] YES [ ] NO When _____/_____/______

For what reason were you seen? __________________________________ Were you helped? [ ] YES [ ] NO

Patient/Guardian's Signature: ____ Date ____/____/_____

Doctor's Signature ____ Date form reviewed ____/____/____

Patient Name ____ **DOB:**_______________________

Section 5: Past Trauma History: *Starting from birth, we all experience thousands of physical, mental, & chemical stresses.* These stresses can cause ***Postural Distortions*** *(misalignments of the spine) and lead to our current health problems.*

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

A. Car Accidents (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't ***feel*** injured!)

Example: 12-1-*2007* ***Type of Collision*: Front end** **10 mph** **Injuries: Neck Whiplash/Neck on Rt. side**

Date:____/____/____ Type of Collision: [ ] Front [ ] Side [ ] Rear Speed _________ Injuries _____________ [ ]Lt [ ]Rt

Date: ____/____/____ Type of Collision: [ ] Front [ ] Side [ ] Rear Speed _________ Injuries _____________ [ ]Lt [ ]Rt

B. Sports Accidents (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example: 12-1-*2007* ***Type of Sport*: Basketball** **Type of injury: Sprained right knee**

Date____/____/____ Type of Sport__________________ Type of Injury:____________________________ [ ]Lt [ ]Rt

Date____/____/____ Type of Sport__________________ Type of Injury:____________________________ [ ]Lt [ ]Rt

C. Slips/falls & bike Accidents (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example: 12-1-*2007* ***Type of Injury: Slipped on ice & bruised Left Elbow***

Date: ____/____/____ Type of Injury:____ [ ]Lt [ ]Rt

Date: ____/____/____ Type of Injury:____ [ ]Lt [ ]Rt

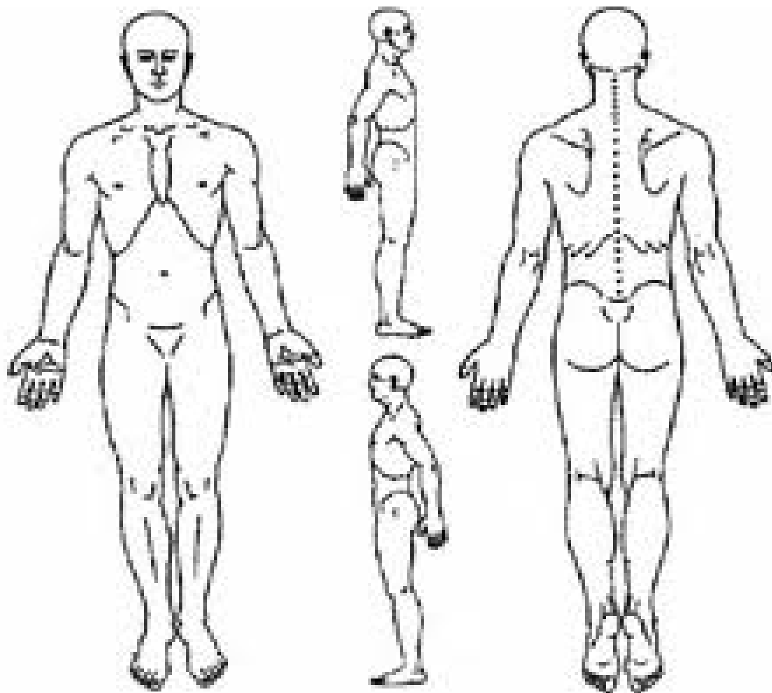
D. Repetitive Injuries (Please list all repetitive injuries you've had in the past.)

Example: 12-1-*2007* ***Type of Injury: Lifting boxes injured lower back***

Date: ____/____/____ Type of Injury:____ [ ]Lt [ ]Rt

Date: ____/____/____ Type of Injury:____ [ ]Lt [ ]Rt

***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



Section 7: **Functional Assessment**:
Check any activities of life that your current conditions are affecting:

- ☐ Exercise/Sports
- Sitting
- ☐ Sit to Stand
- ☐ Standing
- ☐ Walking
- ☐ Driving
- ☐ Sleep/Rolling
- ☐ Reading
- ☐ Computer use
- ☐ Yard work
- ☐ Running
- ☐ Climbing
- ☐ Pushing/Pulling
- ☐ Dressing/Shaving
- ☐ Dishes/Laundry
- ☐ Bending
- ☐ Lifting

Patient/Guardian's Signature: ____ Date ____/____/_____

Doctor's Signature ____ Date form reviewed ____/____/_____

13. Review of systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken/check the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

Patient name

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis Foot/	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders	NONE ○
○	○	Knee injuries	○	○	ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture	Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and Needles	○	○	Numbness	NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive Bruising	NONE ○ Initials ____

d. Respiration

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breathe	○	○	Pneumonia	NONE ○ Initials ____

e. Digestive

ad	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea	NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infections	○	○	Loss of smell	○	○	Loss of taste	NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash	NONE ○ Initials ____

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	NONE ○ Initials ____

Consultation Notes

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: ____________
○	○	Cancer			____________
○	○	Chicken pox			____________
○	○	Diabetes			____________
○	○	Epilepsy			____________
○	○	Glaucoma			____________
○	○	Goiter			____________
○	○	Gout			____________
○	○	Heart disease			____________
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: ____________
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine ____________
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ____________

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: ____________

○	○	Medications (prescription and over-the-counter):

____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Doctor's Initials

Coastal Family Chiropractic
Andrew R. Leach D.C.
Allison C. Leach D.C.

Some health issues are hereditary. Tell Dr. Leach about the health of your immediate family members.

18. Family History

Patient name

FAMILY

Relative	Age (If living)	State of health: Good	State of health: Poor	Illnesses	Age at death	Cause of death: Natural	Cause of death: Illness
Mother		◯	◯			◯	◯
Father		◯	◯			◯	◯
Sister 1		◯	◯			◯	◯
Sister 2		◯	◯			◯	◯
Brother 1		◯	◯			◯	◯
Brother 2		◯	◯			◯	◯
		◯	◯			◯	◯

19. Are there any other hereditary health issues that you know about? ______________________________

____

20. Social History
Tell Dr. Leach about your health habits and stress levels.

SOCIAL

Habit			
Alcohol use	◯ Daily	◯ Weekly	How much?__________
Coffee use	◯ Daily	◯ Weekly	How much?__________
Tobacco use	◯ Daily	◯ Weekly	How much?__________
Exercising	◯ Daily	◯ Weekly	How much?__________
Pain relievers	◯ Daily	◯ Weekly	How much?__________
Soft drinks	◯ Daily	◯ Weekly	How much?__________
Water intake	◯ Daily	◯ Weekly	How much?__________

Hobbies: ______________________________

Question		
Prayer or meditation?	◯ Yes	◯ No
Job pressure/stress?	◯ Yes	◯ No
Financial peace?	◯ Yes	◯ No
Vaccinated?	◯ Yes	◯ No
Mercury fillings?	◯ Yes	◯ No
Recreational drugs?	◯ Yes	◯ No

21. HEALTH OBJECTIVES:

What are your health objectives:______________________________

Name/Address/Phone of the last doctor who put you on a health development program?

____

Were you able to stay on the program? **( ) YES** **( ) NO** How long?__________

What were your results:______________________________

Were your results permanent? **( ) YES** **( ) NO**

Are you healthier today than you were 5 years ago? **( ) YES** **( ) NO**

If so, what did you do to improve your health:______________________________

____

If not, why do you think your health declined?______________________________

____

Will you be healthier 5 years from now than you are today? **( ) YES** **( ) NO**

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? ______________________________

____

What would you like your health to be 5 years from now? ______________________________

____

Consultation Notes

Doctor's Initials

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Over ***seventy percent*** of our patients bring in their children to get adjusted. If you would like to have your children and or spouse checked for subluxations check the box below and they can each ***receive a complementary examination*** if scheduled within two weeks of you starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family

( ) ***I would like my family checked for subluxations within the next two weeks***

DO YOU HAVE INSURANCE TO PRESENT? YES NO

IF YES: Name of carrier ________________________ Policy# ____________________
Group# ___________________

Please present your insurance card to the front desk

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ___ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ___ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ___ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): ___/___/_____**

Initials ___ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ___ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ___ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: ______________________________

Signature ______________________________ Date (MM/DD/YYYY) ____________________

Patient name ____________________

Consultation Notes

CHECKED BY DOCTOR

HEALTH DECISION

( ) Short term solution
( ) Corrective
( ) Wellness
( ) Health Development

Doctor's Initials ____________________

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