



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

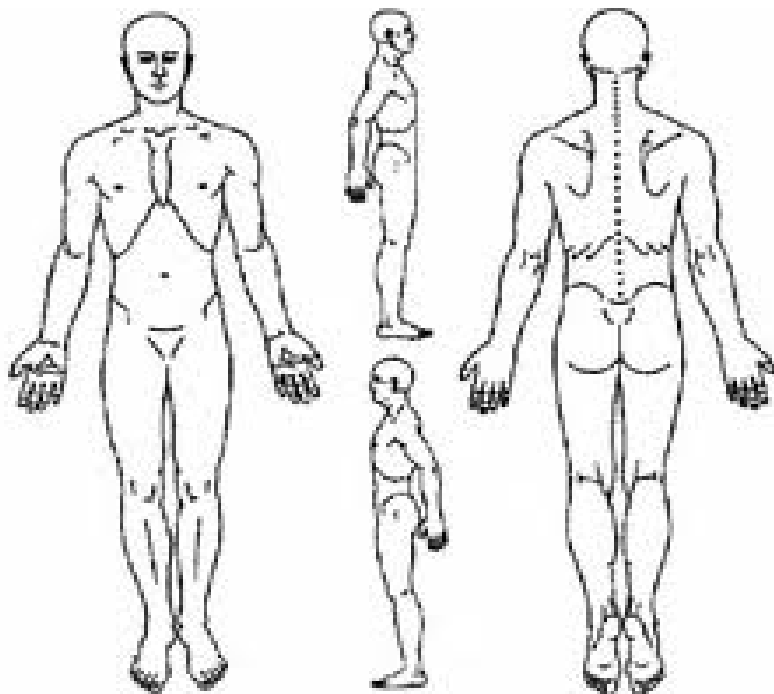
D. Repetitive Injuries (Please list all repetitive injuries you've had in the past.)

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.

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis Foot/ | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | Initials _____ |
| <input type="radio"/> Knee injuries | <input type="radio"/> ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and Needles | <input type="radio"/> Numbness | Initials _____ |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive Bruising | Initials _____ |

d. Respiration

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breathe | <input type="radio"/> Pneumonia | Initials _____ |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | Initials _____ |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infections | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | Initials _____ |

g. Skin

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Skin cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Eczema | <input type="radio"/> Acne | <input type="radio"/> Hair loss | <input type="radio"/> Rash | Initials _____ |

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Thyroid issues | <input type="radio"/> Immune disorders | <input type="radio"/> Hypoglycemia | <input type="radio"/> Frequent infection | <input type="radio"/> Swollen glands | <input type="radio"/> Low energy | Initials _____ |

i. Genitourinary

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Kidney stones | <input type="radio"/> Infertility | <input type="radio"/> Bedwetting | <input type="radio"/> Prostate issues | <input type="radio"/> Erectile dysfunction | <input type="radio"/> PMS symptoms | Initials _____ |

j. Constitutional

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Fainting | <input type="radio"/> Low libido | <input type="radio"/> Poor appetite | <input type="radio"/> Fatigue | <input type="radio"/> Sudden weight gain/loss (circle one) | <input type="radio"/> Weakness | Initials _____ |

Patient name _____

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.

14. Illnesses

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

- | | |
|--|--|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> |
| <input type="radio"/> AIDS | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Alcoholism | <input type="radio"/> Typhoid fever |
| <input type="radio"/> Allergies | <input type="radio"/> Ulcer |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> Other: _____ |
| <input type="radio"/> Cancer | _____ |
| <input type="radio"/> Chicken pox | _____ |
| <input type="radio"/> Diabetes | _____ |
| <input type="radio"/> Epilepsy | _____ |
| <input type="radio"/> Glaucoma | _____ |
| <input type="radio"/> Goiter | _____ |
| <input type="radio"/> Gout | _____ |
| <input type="radio"/> Heart disease | _____ |
| <input type="radio"/> Hepatitis | |
| <input type="radio"/> HIV Positive | |
| <input type="radio"/> Malaria | |
| <input type="radio"/> Measles | |
| <input type="radio"/> Multiple Sclerosis | |
| <input type="radio"/> Mumps | |
| <input type="radio"/> Polio | |
| <input type="radio"/> Rheumatic fever | |
| <input type="radio"/> Scarlet fever | |
| <input type="radio"/> Sexually transmitted disease | |
| <input type="radio"/> 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: _____
- _____
- _____
- Used a crutch or other support
- Used neck or back bracing
- Received a tattoo
- Had a body piercing

16. Treatments

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

- | | |
|----------------------------|--|
| Past <input type="radio"/> | Currently <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> Acupuncture |
| <input type="radio"/> | <input type="radio"/> Antibiotics |
| <input type="radio"/> | <input type="radio"/> Birth control pills |
| <input type="radio"/> | <input type="radio"/> Blood transfusions |
| <input type="radio"/> | <input type="radio"/> Chemotherapy |
| <input type="radio"/> | <input type="radio"/> Chiropractic care |
| <input type="radio"/> | <input type="radio"/> Dialysis |
| <input type="radio"/> | <input type="radio"/> Herbs |
| <input type="radio"/> | <input type="radio"/> Homeopathy |
| <input type="radio"/> | <input type="radio"/> Hormone replacement |
| <input type="radio"/> | <input type="radio"/> Inhaler |
| <input type="radio"/> | <input type="radio"/> Massage therapy |
| <input type="radio"/> | <input type="radio"/> Physical therapy |
| <input type="radio"/> | <input type="radio"/> Nutritional supplements: |
| <input type="radio"/> | List: _____ |
| <input type="radio"/> | _____ |
| <input type="radio"/> | _____ |
| <input type="radio"/> | <input type="radio"/> Medications (prescription and over-the-counter): |
| <input type="radio"/> | _____ |
| <input type="radio"/> | _____ |

PERSONAL

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

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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	Alcohol use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes	<input type="radio"/> No
	Coffee use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes	<input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes	<input type="radio"/> No
	Exercising	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes	<input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes	<input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes	<input type="radio"/> No
	Water intake	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____			
	Hobbies:	_____					

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? _____

Patient name

Consultation Notes

Doctor's Initials

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

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 _____

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