Be Your Best, Inc.
DBA

rockingham chiropractic center

Welcome to our office

Please complete all questions

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

APPLICATION FOR CARE AT ROCKINGHAM CHIROPRACTIC CENTER

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: ____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Fax:_____
Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Occupation: _____ Names and Ages of your children: _____

_____

Name & Number of Emergency Contact: _____
Relationship: _____
Your Insurance Company _____ (No Insurance? No Problem)

HISTORY of COMPLAINT

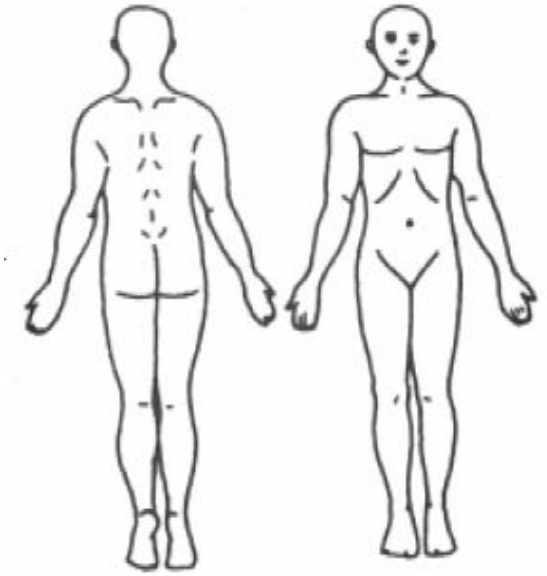
Please identify the condition(s) that brought you to this office:
Chief complaint:

_____

Secondary Complaint(s) or symptoms associated:

_____

When did the problem(s) begin? _____ Is your problem the result of ANY type of accident. ☐ Yes ☐ No
If yes identify type: ☐Auto ☐Work ☐ Home ☐Other (*please explain*):_____
Date of Accident: _____ approximately what time that day? ____am _____pm
Have you reported this accident to anyone? ☐ No ☐ Yes if yes to whom: _____
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? _____ Other forms of treatment tried? ☐ No ☐ Yes
If yes, please state **what** type of treatment you has tried _____, and **who** provided it: _____**How long ago?** _____
What were the results? ☐ Favorable ☐ Unfavorable→ please explain. _____



Please mark on the areas of the diagram with the following letters to describe your conditions

R=radiating B=burning D=dull A=aching
N=numbness S=stabbing/sharp T=tingling

When is the problem at its worst? ☐ AM ☐PM ☐mid-day ☐late PM

How long does it last? ☐ It is constant ☐ I experience it intermittently

What relieves your symptom(s) _____?

What makes them feel worse? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes- If yes when:_____

by whom?_____

What were the results? _____

Name of Previous Chiropractor: _____

How long were you under care: _____ How long ago? _____

On a scale of 1 to 10 with10 being the worst pain and 0 being no pain, rate how you feel today ***(Circle the number)*:**
Primary or chief complaint 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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 **Currently** have and **N** for **never** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:_____

2. PLEASE, identify ALL PAST and any **CURRENT** conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS →			
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Reserved for doctor's use only Systems reviewed with patient:
❑Musculoskeletal ❑
❑Neurological ❑

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drugs ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does you present problem affect these **IDENTIFY TYPE:**

EFFECT:

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

5. Impact of Current Condition on Work Capacity: ☐ No Effect ☐ Painful ☐ Limits ☐ Unable to work

6. How many years of school did you complete? ❑ 1-8 ☐ 8-12 ☐12-14 ☐14-16 ☐ 16 +

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: _____

◆◆◆◆◆

I hereby authorize payment to be made directly to Rockingham Chiropractic 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 Rockingham Chiropractic Center for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

Patient's Name: _____ Today's Date: _____

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:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exercise	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

PATIENT SIGNATURE_____