TREEHIVE CHIROPRACTIC

NEW PRACTICE MEMBER APPLICATION

Name_________________________________Date of Birth____ /____ /____Age______Male/Female

Address__________________________________City_____________________State______ Zip______

Phone: Cell_________________________________Home____________________________________

Social Security #:___________________________Email:____________________________________

Occupation_____________________________Employer's Name______________________________

Status: Single / Married / Divorced / Widowed Spouse's Name________________________________

Number of Children________ Names, Ages,& Gender_____________________________________

____

Who may we thank for referring you?____

Women (if pregnant):

How many weeks along are you? _____ Estimated Due Date: _________

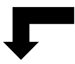
How many times have you been pregnant? _______ Who is your OB/midwife? ______________________

May we contact them about your care in our office? *Yes No*

What are your plans for birth? *Natural Vaginal with epidural Cesarean*

Planned location? *Home Birthing Center Hospital*

Have you had any ultrasounds? *Yes No* How many?_______ Health concerns for you or baby?____________



List The Health Concerns That Brought You Into This Office

Health Concern: List according to severity.↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary : ____________	____________	____________	____________	____________	____________
Second : ____________	____________	____________	____________	____________	____________
Third: ____________	____________	____________	____________	____________	____________

☐ No complaints, I'm here to use chiropractic care for my overall health and wellness.

Have you ever seen other doctors for these conditions? □Yes □No

If Yes: □Chiropractor □Medical doctor □Other____

Who?__________________________ When?__________________________ Results?__________________________

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Current And Past Body Signals Indicating Underlying Dysfunction

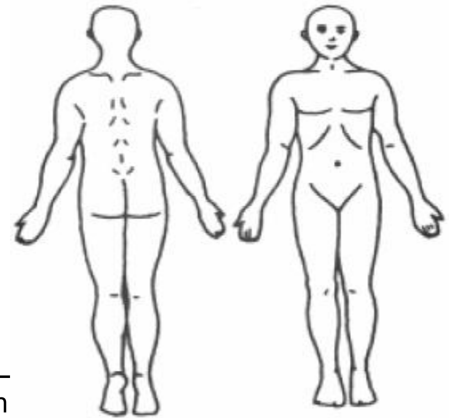
Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Abdominal Pain
___ ADHD/ADD
___ Allergies
___ Anxiety
___ Asthma
___ Autoimmune Disease
___ Bedwetting
___ Blood Disorder
___ Behavioral Issues
___Breast Feeding Issues
___ Blurry Vision
___ Cancer
___ Chest Pain
___ Constipation
___ Depression
___ Dizziness
___ Diabetes Type 1 or 2
___ Disc Herniation
___ Difficulty Swallowing
___ Digestion Issues
___ Double Vision
___ Ear Infections
___ Excess Stress
___ Fatigue
___ Fainting
___ Fibromyalgia
___ Frequent Cold/Flu
___ Headaches
___ Heartburn
___ High Blood Pressure
___Incontinence
___ Infertility
___ Jaw Pain/TMJ
___ Joint Pain/Stiffness
___ Low Back Pain
___ Migraines
___ Menstrual Pain
___ Moody/Irritable
___ Multiple Sclerosis
___ Neck Pain
___ Numbness/tingling
___ Pain: Shoulder, Elbow, Knee, Hip, Ankle, Wrist
___ Painful Defecation
___ Pain after Eating
___ Persistent Cough
___ Rash/redness
___ Rib pain
___ Ringing in ears
___ Sexual dysfunction
___ Seizures
___ Sinus problems
___ Sleep Difficulties
Falling Asleep
Staying Asleep
___ Slurred Speech
___ Tailbone Pain
___ Upper Back Pain
___ Weakness
___ Vision Changes
___ Vomiting

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?

____

When is the problem(s) at its worst? → AM PM Mid-Day Late PM

____

List all surgical operations & years: ______________________________

List any other injuries to your spine, minor or major, that the doctor should kn

____

List all over the counter & prescription medications you are on, & the reason for each:____

Have you ever been in an auto accident? List all:______________________________

Have you ever been knocked unconscious? □Yes □No Fractured A Bone? □Yes □No

If yes to either of the above, please describe:______________________________

Other trauma:____

SOCIAL HISTORY

1. Smoking: How often? □ Daily □ Weekends □Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours?□ Yes □ No

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QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain ______ Back pain (4) ______ Headaches (8) ______ Worst possible pain
0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? ______%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? ______%

ACTIVITIES OF LIFE

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

ACTIVITY:	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
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform