PATIENT APPLICATION FORM **Today's Date:__/__/__**

Last Name:_____ First Name:_____ Middle Initial:_____
Race: White/Caucasian - Asian - African American - Hispanic — Other_____
Nickname:_____ Gender: ☐ Male ☐ Female
Date of Birth:_____ (Age:___)
How did you hear about us? ☐ Google ☐ Social Media ☐ Flyer ☐ Health Talk/Workshop
☐Driving by office ☐Referred by Friend/Acquaintance (Name:_____)
☐ Other (please explain:_____) ☐ Health Talk/Workshop(Name:_____)
Address:_____ City:_____ State:___ Zip:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Email:_____
Occupation:_____ Employer:_____
Marital Status:_____ Spouse name and occupation:_____
Number of children and ages:_____
Have you ever received chiropractic care? ☐ Yes ☐ No
When is the last time you had x-rays?_____
Females Only: Are You Pregnant? ☐ Yes ☐ No ☐ I don't know
Have you ever been in an accident? ☐ Yes ☐ No ☐ Work ☐ Auto ☐ Other:_____
Nature of accident:_____ Date of accident:_____
Did you require hospitalization post accident? ☐ Yes ☐ No
Did you lose work as a result of accident? ☐ Yes ☐ No How many?_____
Is insurance involved? ☐ Yes ☐ No Which company?_____

_____
Attorney's name? ☐ n/a _____ Claim #:_____

Family History: Did your mother or father have any of the following:
High blood pressure, Heart Attack, Emphysema, Seizures — Convulsions, Asthma, Diabetes, Kidney disease, Pace maker, Ulcers, Digestive trouble, Stroke, Arthritis, Mental illness, Thyroid, Cancer, Osteoporosis

Any Surgeries?_____ Implants?_____ Broken Bones?_____
Trauma History: Car Accidents?_____ Serious Illnesses?_____ Allergies?_____
Social History: Drugs?_____ Smoker Y/N?_____Years_____ Caffeine? Y/N Alcohol? Y/N
Diet History: Do you take supplements?_____ Vitamins?_____ Other?_____
Exercise History: Do you exercise? Y/N What kind?_____ How Often?_____
Other Hobbies:_____
Current Meds:_____

Anything else you would like to discuss with us or let us know?_____
_____

PRESENT COMPLAINT

Major Complaint:_____
Pain or problem started when:_____
Pains are: □ Sharp □ Dull □ Constant □ Intermittent Is condition getting progressively worse? □ Yes □ No
Rate the pain on a scale of 1 to 10, 10 being the worst pain you've ever experienced:_____
What activities aggravate your condition/pain? _____
Is condition worse during certain times of the day? □ Yes □ No If so when?_____
Is this condition interfering with: □Work □Sleep □Routine □Other_____
Other doctors seen for this condition:_____
Any home remedies?_____
Have you been under drug and medical care? □ Yes □ No
If yes, please explain:_____
What medications are you taking and for how long?_____
Have you had surgery? □ Yes □ No
For what? _____ When?_____
What side effects (if any) did you feel from the drugs and surgery?

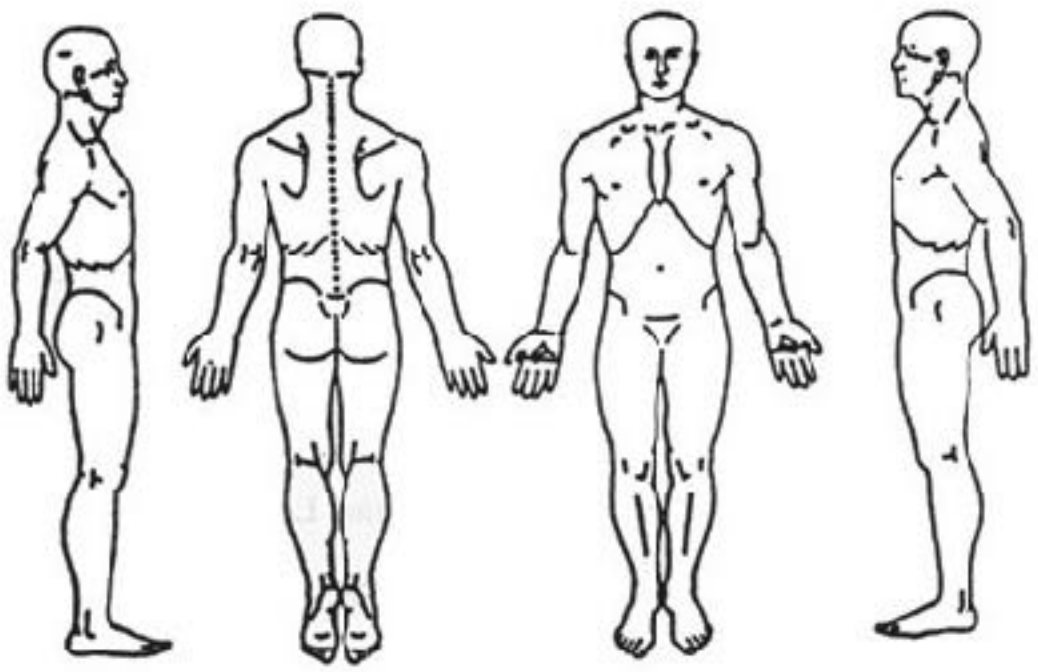
SYMPTOMS & ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Have you ever had an issue with any of the following? Please indicated with an **N** for if you have the condition **NOW (within the past 6 months)** or **P** if you ever had the condition in the **PAST**

□Headaches	□Face Flushed	□Light Bothers Eyes
□Neck Pain	□Neck Stiff	□Loss of Memory
□Sleeping Problems	□Pins & Needles in Legs	□Ears Ring
□Back Pain	□Pins & Needles in Arms	□Fever
□Nervousness	□Numbness in Fingers	□Fainting
□Tension	□Numbness in Toes	□Loss of Smell
□Irritability	□Shortness of Breath	□Loss of Taste
□Chest Pain	□Fatigue	□Diarrhea
□Dizziness	□Depression	□Feet Cold
□Food Allergies	□Muscle Cramps	□Hands Cold
□Stomach Upset	□Constipation	□Cold Sweats
□Loss of Balance	□Buzzing in Ears	□Menstrual Cramps/PMS
□Wrist Pain	□Knee Pain	□Foot Pain
□Arthritis	□Leg Cramps	□Hemorrhoids
□High Cholesterol	□High Blood Pressure	□Gall Bladder Pain
□Swelling Joints	□Dry Skin	□Hard to Lose Weight
□Shoulder Pain	□Depression	□Difficulty Urinating

Please use the diagram and key below to describe your condition:

0 0 0 0 0 Dull
x x x x x Sharp
———— Pain or Discomfort Radiates/travels/shoots
- - - - - - - Tingling
□□□□ Numbness



Activities of Daily Living Circle which of the following are affected from your health issues and rate what percentage of severity the limitation has and how much pain it causes on a scale of 1 to 10, 10 being severe.

Bending Pain __/10 __%	Lifting __/10 __%	Playing Sports __/10 __%
Sit to Stand __/10 __%	Sitting __/10 __%	Dancing __/10 __%
Doing Chores __/10 __%	Pushing __/10 __%	Sleeping __/10 __%
Dressing __/10 __%	Reading __/10 __%	Watching TV __/10 __%
Driving __/10 __%	Running __/10 __%	Working __/10 __%
Gardening __/10 __%	Rolling Over __/10 __%	Walking __/10 __%

Other (Please Specify:_____) __/10 __%

Nearly all of our patients are on wellness care to help them reach a new improved level of living. Which of the following would you like to improve in your life or benefit from?
(Circle and fill in reason)

Better Posture:_____
Improved Nutrition:_____
Better Sleep:_____
Better Fitness:_____
Weight Loss:_____
Stress Relief:_____
Focus:_____

Office Policies: Please initial these categories to confirm that you read and understand our office policies. Our goal is to provide excellent service to every patient. From our experience, these guidelines help to create the best office environment for all of our patients. Initial_____

Office Hours Initial_____
Monday, Wednesday: 8am-6pm
Tuesday: noon-6pm, Friday: 8am-2pm
Saturday: By Appointment Only, Thursday & Sunday: Closed

Appointment Scheduling/Missed Appointments Initial_____
The doctors have created a specific protocol for your care so that you can achieve the best results for your health care goals. Thus, personal appointments are made for you so that you can stay on track to achieve your goals. If an appointment must be changed, 24 hour notice is appreciated. All missed appointments should be made up later in the same day or within 24 hours. Please let us know and changes will be made accordingly.

Broken Appointments Initial_____
"No Show" or Missed Appointments are subject to a $25.00 charge. Please give a 24 hour notice so that the Doctors may serve others in need at your time. The "broken appointment fee" also applies to the "Health Care Classes." If appointments are repeatedly missed we will, regretfully, have to dismiss you from care.

Children/Family Initial_____
Once you understand that the nervous system controls and coordinates all functions of the body and subluxation interferes with nerve flow, most of our patients want everyone in their family to be checked for hidden damage in their spine. We have a cost-effective, discounted family fee program for you if you have your family scheduled within 14 days of starting care.

Financial Agreements Initial_____
It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

Interruption of Care Initial_____
In the unlikely event it is necessary to discontinue your care for any reason, any outstanding fees become payable and due immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

Chiropractic Excellence Initial_____
The Doctors of Strong Performance Chiropractic occasionally will be out of the office for continuing education seminars to further their eduction and enhance your experience as a patient under care. We will build your schedule around those times.

Research Initial_____
I hereby consent for my health information to be used for Research and Health Purposes.

Social Media Initial_____
I hereby consent for Strong Performance Chiropractic, LLC to use any audio, video, or photo obtained in the office on social media or other promotional products.

Note on Spinal Healing Initial_____
Remember, spinal correction and healing takes time. If you do not feel satisfied with your body's response, please make an appointment to discuss this with the Doctors. We want you to get the most from your chiropractic care. These conversations need a separate appointment so that the doctors have time to address your concerns. Please do not bring these concerns to the doctors attention during your daily treatment visits.

I have read and understand the above policies and agree to abide by them.
Signed_____ Date _____
Witness_____ Date _____