



**APPLICATION FOR CARE AT AVENUE ONE CHIROPRACTIC**

**PRACTICE MEMBER DEMOGRAPHICS Today's Date: \_\_\_ / \_\_\_ / \_\_\_ PMID: \_\_\_\_\_**

Name: \_\_\_\_\_ Birth Date ----- \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Cell Carrier: \_\_\_\_\_  
 Marital Status:  Single  Married  Widowed  Divorced Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Do you have Insurance:  Yes  No (Self Pay)  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Number of children and ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
**Whom may we thank for referring you to this office?** \_\_\_\_\_

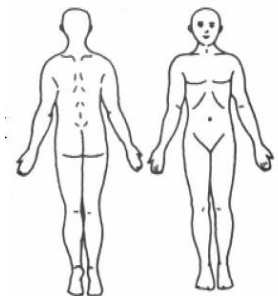
**HISTORY of COMPLAINT**

Health Concerns: (List according to severity)	Rate of Severity 1 = Mild 10 = Unbearable	When did this episode start?	Did you have this condition before & when?	Did the problem begin with an injury?	Constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst?  AM  PM  mid-day  late PM  
 How long does it last?  It is constant **OR**  I experience it on and off during the day  
**OR**  It comes and goes throughout the week

How did the injury happen?  
 \_\_\_\_\_  
 Condition(s) ever been treated by anyone in the past?  No  Yes **If yes**, when: \_\_\_\_\_ by whom? \_\_\_\_\_  
 How long were you under care: \_\_\_\_\_ What were the results? \_\_\_\_\_  
 Name of Previous Chiropractor: \_\_\_\_\_  N/A

**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? \_\_\_\_\_

Is your problem the result of ANY type of accident?  Yes,  No  
 Identify any other injury(s) to your spine, minor or major, that the doctor should know about:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have these symptoms effected:  Work  Family life  Exercise  Sleep  
 Other: \_\_\_\_\_

What are your health goals? 1) \_\_\_\_\_ 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**PAST HISTORY**

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? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried:  No  Yes **If yes**, please state **what** type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ **How long ago?** \_\_\_\_\_  
 What were the results.  Favorable  Unfavorable  please explain.

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

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 or **N** for **Never** have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability  
 \_\_\_ Cancer \_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular  
 \_\_\_ Other serious conditions: \_\_\_\_\_

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

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

**SOCIAL HISTORY**

1. **Smoking:** How often?  Daily  Weekends  Occasionally  Never  
 2. **Alcoholic Beverage:** Consumption occurs  Daily  Weekends  Occasionally  Never  
 3. **Recreational Drug use:** How often?  Daily  Weekends  Occasionally  Never

**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 True North Chiropractic, 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 True North Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
**Patient or Authorized Person's Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date Completed**

\_\_\_\_\_  
**Doctor's Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date Form Reviewed**

**AVENUE ONE CHIROPRACTIC**  
Automobile/PI Accident or Work Comp Questionnaire

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**PMID#:**

Dear Patient,

This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Thank you.

**Please answer all questions completely.**

Please explain in detail how your accident happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

List the extent of your injuries as you know them: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Did you require post-accident hospitalization?  Yes  No

**Check symptoms you have noticed since the accident:**

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Light Bothers Eyes	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Head Seems to Heavy	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Neck Stiff
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Fainting
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Loss of Balance
<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Fever	<input type="checkbox"/> Irritability
<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Stomach Upset		

Symptoms other than above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Hospitalized?  Yes  No If yes, admitted? \_\_\_\_\_ How long? \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Name of Doctor(s): \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

If so, what was the doctor's name? \_\_\_\_\_ D.C., M.D., D.O., D.D.S.

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms ...  Improving?  Getting worse?  Same?

Driver of other vehicle (if any):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable):

Name \_\_\_\_\_ Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

Have you retained an attorney?  Yes  No

If so, his/her name and address \_\_\_\_\_

You were heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Other vehicle was heading North/ East/ South/ West on \_\_\_\_\_ (street or highway)

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

You were struck from Behind/ Front/ Left Side/ Right Side \_\_\_\_\_

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_ 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:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

**List Prescription & Non-Prescription drugs you take:**

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**Patient signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please read carefully:**

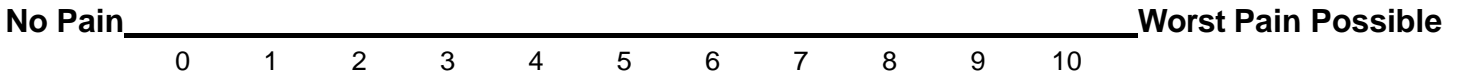
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

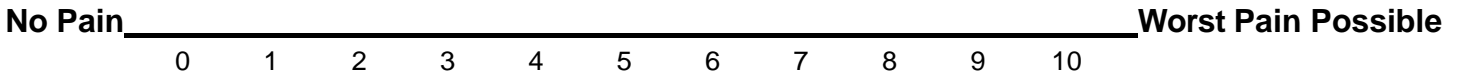
**Example:**



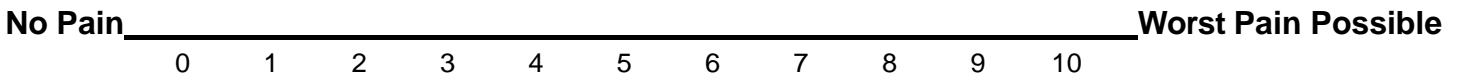
**1 – What is your pain RIGHT NOW?**



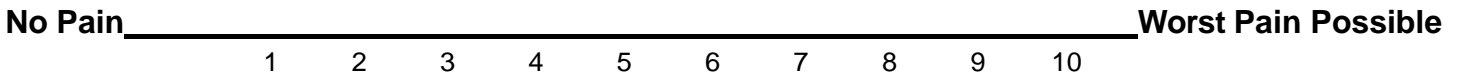
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

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**Examiner**

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