APPLICATION FOR CARE AT DICKASON CHIROPRACTIC

Today's Date: _______________ ***How did you hear about our office?*** → ____

PATIENT DEMOGRAPHICS ☐ Yes, please send me email / text appointment reminders

Name: __________________________________ Nickname: ___________ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female
Address: ____ City: ________________________________ State: _____ Zip: ______________
E-mail Address: ____________________________________ Home Phone: ___________________________ Fax: ______________________
Mobile Phone: ____________________________________ Work Phone: ___________________________ Fax: ______________________
Employer: ____ Occupation: ____
Name of Spouse: __________________________________ Spouse's Employer: ____________________ Spouse's Birth Date: ____________
Occupation: ______________________________________ Names and Ages of your children: _____________________________________
Name & Number of Emergency Contact: ____ Relationship: ____________________________

HISTORY of COMPLAINT(s) ☐ Preventative Care

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:
Primary problem ____ 2nd _____________ 3rd _____________4th ______________

Please answer each of these questions ***for each complaint:***

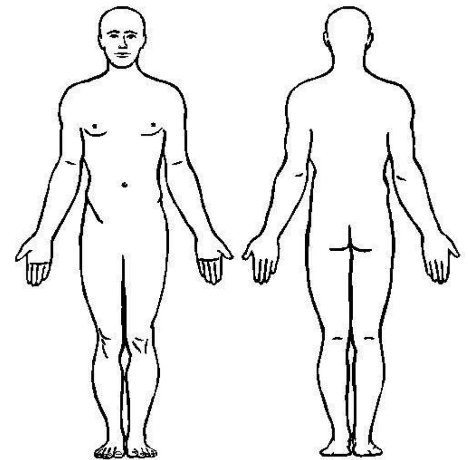
When did each **problem/symptom begin**: Primary complaint _____________ 2nd _____________ 3rd _____________4th ______________
Number of times you have experienced: Primary complaint _____________ 2nd _____________ 3rd _____________4th ______________
When was the last **episode**? Primary complaint _____________ 2nd _____________ 3rd _____________4th ______________
What relieves your symptom(s)? Primary complaint _____________ 2nd _____________ 3rd _____________4th ______________
What makes them feel worse? Primary complaint _____________ 2nd _____________ 3rd _____________4th ______________

Please mark with a "C" if you feel your pain **constantly** (**75-100%** of the time), an "F" if you experience it **frequently** (**50-75%**), an "I" if you experience it **intermittently** (**25-50%**), or an "O" if you experience it **occasionally** (**0-25%**) on the line next to each complaint:
Primary complaint _____ 2nd _____ 3rd _____ 4th _____

On a scale of **0 to 10** with **0** being no pain and **10** being the worst pain, rate how you feel ***today*** for each complaint ***(Circle the number)***:

Primary complaint:	0	1	2	3	4	5	6	7	8	9	10
Second complaint:	0	1	2	3	4	5	6	7	8	9	10
Third complaint:	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint:	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp / **S**tabbing **T = T**ingling **C = C**ramping **ST = St**iffness
Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM



Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**:
Who provided: ____
How long ago? ______What **type** of treatment did you receive? ______________________
What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable,** please explain:
____
List any **medications** taken to treat these conditions: ____________________________
Did they help? ☐ No ☐ Yes If you still take them how often? ______________________
Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: ________
Name of Previous Chiropractor: ___________________________________
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**
How long ago? ________ Please explain what type of accident: _______________________

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:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___Diabetes ___ Other serious conditions

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

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

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → how often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: consumption occur → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. 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)

2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know

3. Any other hereditary conditions the doctor should be aware of ❑ No ❑Yes ______________________________

4. Please list any known allergies: ____

____

How have your current complaints/problems been affecting your daily activities of living?

ACTIVITIES /HOBBIES	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Lying to sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sitting still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Standing still	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Lifting Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Pulling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Exercise regime	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Reading/Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Tie shoes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Hobbies (please state)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform

Please List ALL Medications, Prescription or Over-The-Counter, that you are currently taking, as well as Vitamins, Supplements, Botanical and/or Homeopathic Remedies: ( ) I am not currently taking anything

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Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.
I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted at this by the doctor(s) in practice all my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

I acknowledge that as a patient I can request a private conversation with Dr. Dickason that affords the requisite amount of privacy and confidentiality. Dr. Dickason has special times available to allow the requisite amount of time for these appointments.

______________________________ _____ - _____ - _____

Patient or Authorized Person's Signature Date Completed

Reviewed by ____________ ❑ Interviewer's Initials ____________ ❑ Doctor's Initials