WESTCHASE
CHIROPRACTIC AND WELLNESS

We Believe in Awakening Your Greatest Innate Potential

PATIENT APPLICATION FORM

WELCOME TO OUR OFFICE. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to helping you achieve maximum health!

Patient Signature _____ Date: _____

Westchase Chiropractic
10981 Countryway Blvd
Tampa, FL 33626

APPLICATION FOR CARE

Date: _____

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ Gender M F

Email Address: _____

Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Occupation: _____ # of Children: _____ Spouse's Name: _____

Name & Number of Emergency Contact: _____

Relationship: _____ Do you have insurance? ☐ Yes ☐ No

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

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of **1** to **10** (zero = no pain; 10 = worst pain)

1. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

2. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

3. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

4. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? _____

When is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening

How long does it last? ☐ constant throughout day ☐ I experience it on and off during the day

☐ it comes and goes throughout the week

How did the injury happen? _____

Has the condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

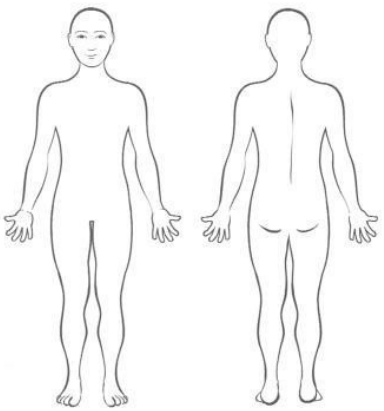
If yes, when: _____ and by whom? _____

How long were you under care: _____ What were the results: _____

When was your last chiropractic visit? _____

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R = **R**adiating
B = **B**urning
D = **D**ull
T = **T**ingling
A = **A**ching
N = **N**umbness
S = **S**harp/**S**tabbing



What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of any type of accident? Yes No

Explain: _____

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: _____

_____

_____

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently taking: _____

_____

_____

_____

_____

_____

Females: Is there ***any chance*** that you are pregnant? □ Yes □ No

If no, when was your last cycle? _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? □ Yes □ No

If yes, how many times? _____

Please identify any and all types of jobs, activities, or events you have experienced 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:

P = in the **P**ast **C** = **C**urrently **N** = **N**ever have had:

___ Dislocations	___ Fracture	___ Heart Attack	___ Cerebral Vascular
___ Tumors	___ Disability	___ Osteoarthritis	___ Other: _____
___ Rheumatoid Arthritis	___ Cancer	___ Diabetes	

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

	Condition	How Long Ago	Type of Care Received	By Whom
INJURIES				
SURGERIES				
CHILDHOOD DISEASES				
ADULT DISEASES				

SOCIAL HISTORY

1. Smoking: □ cigars □ pipe □ cigarettes □ Daily □ Weekends □ Occasionally □ Never
2. Alcoholic beverage consumption: □ Daily □ Weekends □ Occasionally □ Never
3. Recreational drug use: □ Daily □ Weekends □ Occasionally □ Never
4. Hobbies/recreational activities/exercise regime: _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? □ No □ Yes

   If yes whom: □ grandmother □ grandfather □ mother □ father □ sibling(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 Westchase 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 affecting 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 Westchase Chiropractic for any and all services I receive at this office that are not covered under a healthcare plan.

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Signature of Doctor Date

ACTIVITIES OF DAILY LIVING

Patient Name: _____ Date: _____

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life.

Reading/Concentration	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying/Lifting (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bending	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Stand to Sit Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other:	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
:	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Please mark the listed items below as: **P (Past)** **C (Currently)** **N (Never)**

____ Headache
____ Neck Pain
____ Jaw Pain, TMJ
____ Shoulder Pain
____ Upper Back Pain
____ Mid Back Pain
____ Low Back Pain
____ Hip Pain
____ Back Curvature
____ Scoliosis
____ Numb/Tingling Arms, Hands, and Fingers
____ Numb/Tingling Legs, Feet, and Toes
____ Knee Problems
____ Foot Problems
____ Swollen/Painful Joints
____ Pregnant (Now)
____ Frequent Colds/Flu
____ High Cholesterol
____ Other

____ Pain w/ Cough/Sneeze
____ Allergies
____ Sinus/Drainage Problem
____ Convulsions/Epilepsy
____ Tremors
____ Dizziness
____ Loss of Balance
____ Fainting
____ Double Vision
____ Blurred Vision
____ Ringing in Ears
____ Hearing Loss
____ Asthma
____ Difficulty Breathing
____ Lung Problems
____ Heart Problem
____ Heartburn
____ Chest Pain
____ High Blood Pressure
____ Low Blood Pressure
____ Ulcers

____ Digestive Problems
____ Colon Trouble
____ Diarrhea/Constipation
____ Kidney Trouble
____ Gall Bladder Trouble
____ Liver Trouble
____ Prostate Problems
____ Impotence/Sexual Dysfun.
____ Menstrual Problems
____ PMS
____ Menopausal Problems
____ Depression
____ Irritable
____ Bed Wetting
____ Skin Problems
____ Learning Disability
____ ADD/ADHD
____ Eating Disorder
____ Trouble Sleeping

Patient Signature _____ Date _____

Notes