Welcome back to CROWLEY HIROPRACTIC LINIC

Health and Wellness thru the 5 Essentials,

the way Nature intended.

(912) 265-2129

PLEASE PRINT CLEARLY **Application for Care at CROWLEY CHIROPRACTIC CLINIC**

Today's Date: _____ *Whom may we thank for referring you to this office?* → _____

This information is confidential. We need this information in order to help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you, *Team Crowley*

PATIENT DEMOGRAPHICS

Full (MI) Name: _____ Birth Date: _____ Age: _____

Nick Name: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ PT Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ PT Declined ☐ Unknown

Address: _____ City: _____ State: _____ Zip: _____

Mobile: _____ Home Phone: _____ Work Phone: _____

E-mail Address: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed Occupation: _____ Employer: _____

Are you: ☐ FT ☐ PT ☐ Military ☐ Self Employed ☐ Homemaker ☐ Student ☐ Not Employed

Do you have Insurance you'd like to use? ☐ Yes ☐ No Is it in your name? ☐ Yes ☐ No

Spouse's Name: _____ Spouse's Employer: _____

If at home, # of children, names and ages: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

SOCIAL HISTORY

Tobacco: ☐ cigars ☐ pipe ☐ cigarettes ☐ chew → **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never ☐ Used To

Have you smoked in the last 2 years? ☐ Yes ☐ No Have you received any smoking cessation intervention? ☐ Yes ☐ No

Alcoholic Beverage: consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug use: consumption occurs → ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

What Vitamins/Nutritional Supplements are you taking?

What medications are you taking?

What medications are you allergic to?

If under 40, have you been diagnosed with mild, moderate, or severe persistent asthma and prescribed an inhalant medication? ☐ Yes ☐ No

Have you ever been diagnosed with CAD **and** prescribed a lipid-lowering therapy? ☐ Yes ☐ No

Have you been diagnosed with heart failure and paroxysmal or chronic atrial fibrillation? ☐ Yes ☐ No

Were you prescribed warfarin therapy? ☐ Yes ☐ No Have you ever been diagnosed with hypertension? ☐ Yes ☐ No

If you have ever been diagnosed with any of the following conditions, please indicate:

Had/Have	Had/Have	Had/Have	Had/Have	Had/Have
☐ / ☐ Broken Bone	☐ / ☐ Dislocations	☐ / ☐ Tumors	☐ / ☐ Rheumatoid Arthritis	☐ / ☐ Fracture
☐ / ☐ Disability	☐ / ☐ Cancer	☐ / ☐ Diabetes	☐ / ☐ Cerebral Vascular	☐ / ☐ Osteo Arthritis

☐ / ☐ Other serious conditions: _____

NAME: _____ SIGNATURE: _____ DT: _____

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HISTORY of COMPLAINT

Please identify the condition(s) that brought you to our office: Primary: _____ (____)

Secondary: _____ (____) Third: _____ (____)

On a scale of **1** to **10** with **10** being the worst pain, rate your above complaints by adding it in the parenthesis provided above.

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ mid-day ☐ PM ☐ late PM

☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

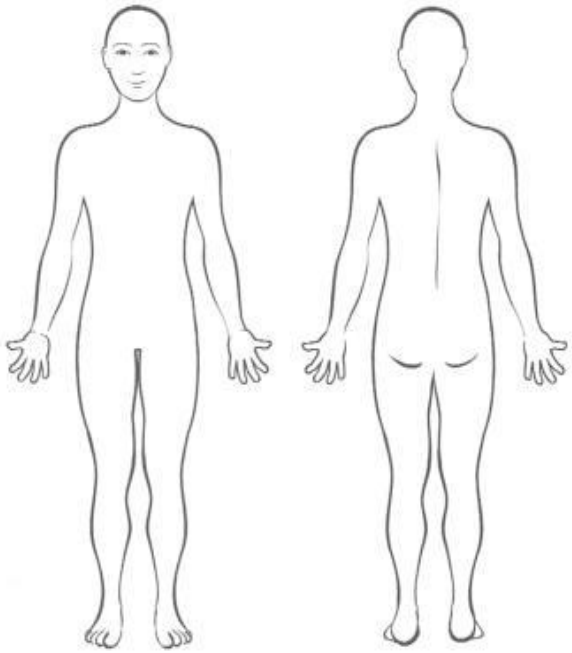
If injury, how did it happen? _____

Condition(s) ever been treated before? ☐ Yes ☐ No If yes, when: _____ By whom? _____

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

Name of Previous Chiropractor: _____ or ☐ N/A

Please **Mark** the areas on the Diagram with the below letters to describe your symptoms:



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

What relieves your symptoms? _____

_____

What makes them feel worse? _____

_____

Anything else? _____

_____

Ex: Work around the house – lifting, bending, woke up with stiff neck, "back went

_____

DAILY ACTIVITIES: Effects of Current conditions On Performance

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

Bending	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports/Recreation	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying/Lifting	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting/Watching TV	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

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Climbing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

ROWLEY HIROPRACTIC LINIC

PAST HISTORY

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: _____

_____

Mark only those conditions that you have either had in the past or currently have:

Had / Have		Had / Have		Had / Have	
☐ / ☐	ADD/ HDAD	☐ / ☐	Gall Bladder Trouble	☐ / ☐	Mid-Back Pain
☐ / ☐	Allergies	☐ / ☐	Headaches	☐ / ☐	Mood Changes
☐ / ☐	Asthma	☐ / ☐	Hearing Loss	☐ / ☐	Neck Pain
☐ / ☐	Bed Wetting	☐ / ☐	Heart Problems	☐ / ☐	Pacemaker
☐ / ☐	Blurred Vision	☐ / ☐	Heartburn	☐ / ☐	Numb/Tingling arms, hands
☐ / ☐	Cancer	☐ / ☐	Hepatitis (A, B, C)	☐ / ☐	Numb/Tingling legs, feet, toes
☐ / ☐	Chest Pain	☐ / ☐	High Blood Pressure	☐ / ☐	Pain w/Cough/Sneeze
☐ / ☐	Colon Trouble	☐ / ☐	Hip Pain	☐ / ☐	PMS
☐ / ☐	Convulsions/ Epilepsy	☐ / ☐	Impotence/Sexual Dysfunc.	☐	Pregnant (Now)
☐ / ☐	Depression	☐ / ☐	Irritability	☐ / ☐	Prostate Problems
☐ / ☐	Diarrhea/Constipation	☐ / ☐	Jaw Pain/TMJ	☐ / ☐	Ringing in Ears
☐ / ☐	Diabetes	☐ / ☐	Kidney Trouble	☐ / ☐	Scoliosis
☐ / ☐	Difficulty Breathing	☐ / ☐	Learning Disability	☐ / ☐	Shoulder Pain
☐ / ☐	Digestive Problems	☐ / ☐	Liver Trouble	☐ / ☐	Sinus/Drainage Problem
☐ / ☐	Dizziness	☐ / ☐	Loss of Balance	☐ / ☐	Skin Problems
☐ / ☐	Double Vision	☐ / ☐	Low back Pain	☐ / ☐	Swollen/Painful Joints
☐ / ☐	Eating Disorder	☐ / ☐	Low Blood Pressure	☐ / ☐	Tremors
☐ / ☐	Fainting	☐ / ☐	Lung Problems	☐ / ☐	Trouble Sleeping
☐ / ☐	Fibromyalgia	☐ / ☐	Menopausal Problems	☐ / ☐	Ulcers
☐ / ☐	Foot or Knee Problems	☐ / ☐	Menstrual Problems	☐ / ☐	Upper Back Pain
☐ / ☐	Frequent Colds/Flu	☐ / ☐	Migraines	☐ / ☐	Other:

PLEASE identify ALL PAST and any CURRENT conditions:

ISSUE RECEIVED	WHEN	TYPE OF CARE
INJURIES →		
INJURIES →		
INJURIES →		
INJURIES →		

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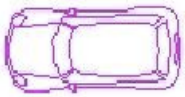
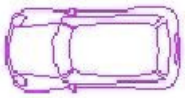
INJURIES →
INJURIES →
SURGERIES →
SURGERIES →
SURGERIES →
SURGERIES →
CHILDHOOD DISEASES →
ADULT DISEASES →

- **When was your most recent auto accident?** _____
  - Where were you sitting? Please X-mark your location -
  - What speed was the collision? _____
  - Type of impact: please X-mark point of impact -
  - Was treatment received? Please describe _____





- **When was your most recent strain / stress at work?** _____
  - Please describe the manner of the injury _____
  - Was treatment received? Please describe _____
  - Does your job require you remain in long-term certain postures? _____
    (*i.e. all day seating, repeated lifting, long term computer use)*
- **Spinal traumas in the past?** _____
  - Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field: _____
  - Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident: _____

FAMILY HISTORY

Does anyone in your family suffer with the heart disease, cancer, diabetes, or arthritis? ☐ 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

Any other hereditary conditions the doctor should be aware of. ☐ No ☐ Yes: _____

I understand that I am directly and fully responsible to Crowley Chiropractic Clinic for all chiropractic care I receive.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

I agree that this Maximized Living Health Center does not provide legal services, advice or counsel. Some advice, advertising and materials provided by this Maximized Living Health Center may have legal implications. I agree to seek independent legal counsel before implementing said advice, advertising and materials. I agree to hold this Maximized Living Health Center harmless from any legal action taken by others against myself for any implementation that caused in whole or in part said legal action. I assume all liability and responsibility for my compliance to any State or Federal law, rule or their interpretation thereof by the governing authority.

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