Welcome 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

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

Today's Date: _____

Thank you for choosing our office for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance.

We offer "transient" care for patients who don't live in our area and have found themselves in discomfort away from their primary chiropractic care. Much unlike our traditional service process, we allow for the absence of X-Rays and only a brief history from you if we can at least get a report from your primary chiropractor.

In exchange for our expeditious and affordable service, we ask you pay us directly, today and allow us to avoid the time consuming and expensive "chasing" of insurance benefits. *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

☐ Self Pay ☐ Personal Injury _____ Do you have Insurance: ☐ Yes ☐ No

Name & Phone of Emergency Contact: _____ Relationship: _____

Primary Chiropractic Physician:

Dr. Name: _____ Clinic Name: _____ Web: _____

Phones: Office: _____ Other: _____ Email Address: _____

SOCIAL & MEDICAL 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

Do you take any Vitamins/Nutritional Supplements?

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

PLEASE identify ALL PAST and any CURRENT conditions:

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

SURGERIES →
SURGERIES →
CHILDHOOD DISEASES →
ADULT DISEASES →

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

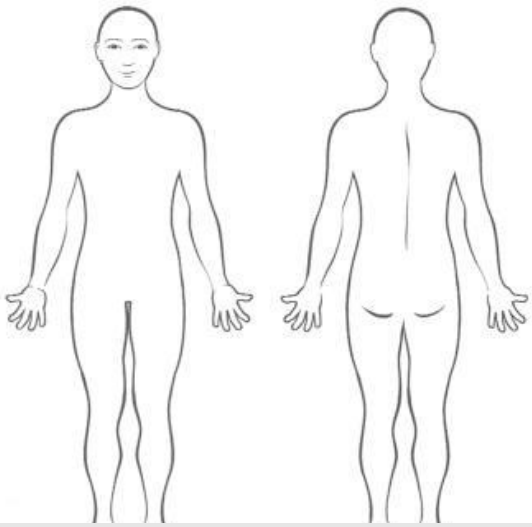
If injury, how did it happen? _____

Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No If yes, when: _____ By whom? _____

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

Please **Mark** the areas on the Body Diagram with the following 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? _____

_____

_____

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

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. _____

Anything else? _____

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

I agree that this Maximized Living Health Center does not provide legal services, advice or counsel. Some advice, advertising and materials provided by this Crowley Chiropractic may have legal implications. I agree to seek independent legal counsel before implementing said advice, advertising and materials. I agree to hold Crowley Chiropractic 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.

NAME: _____ SIGNATURE: _____ DT: _____

☐ Check if you are Guardian of PT

internal: HRN: _____ DR INT: _____ DT: _____