

**APPLICATION FOR CARE AT Ascherl Chiropractic Sports & Wellness**

**Patient Information**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: (check one)  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: ( ) \_\_\_\_\_ Home/Work Phone: ( ) \_\_\_\_\_  
 Email: \_\_\_\_\_ (I authorize my doctor to contact me via the email address provided)  
**Referred By:**  Patient/Friend  Physician  Advertisement  Community/Sports Event  Website/Online Search  
 Name of Person or Event: \_\_\_\_\_ (We like to say Thank You to the person who referred you)  
 Marital Status:  Single  Married  Other Spouse's Name: \_\_\_\_\_ # of Children and ages: \_\_\_\_\_  
 Name of Parent or Legal Guardian (if patient is under 18): \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  Retired  Student  
 Race:  
 White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Native Hawaiian or other Pacific Island  Other: \_\_\_\_\_  I choose not to specify  
 Ethnicity: (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify  
 Preferred Language: \_\_\_\_\_  
 Emergency Contact Information: Full Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insurance policy name, if any? \_\_\_\_\_ Insured's Name: \_\_\_\_\_ Insured DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insurance policy number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Method of payment for this visit:  Cash  Check  Credit card

**Patient Condition**

Reason(s) for visit: \_\_\_\_\_  
 Is this condition due to an accident?  Yes  No  Auto  Work  Home  Other: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 What was the mechanism of accident/injury? \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_  
 How often do you have this problem? \_\_\_\_\_ How long does the pain last? \_\_\_\_\_  
 Does the pain radiate?  Yes  No If yes, explain: \_\_\_\_\_  
 Does it interfere with your:  Work  Sleep  Daily Routine  Recreation  
 Activities or movements that are difficult / painful to perform:  
 Sitting  Standing  Walking  Bending  Lying down  
**Mark an "X" on the picture where you are experiencing symptoms ----->**

Circle your pain on the below scale of 0 to 10:

**At rest:**

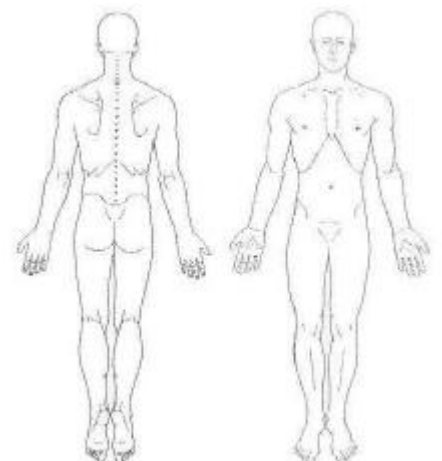
No Pain	0	1	2	3	4	5	6	7	8	9	10	Extreme Pain
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**With Activity:**

No Pain	0	1	2	3	4	5	6	7	8	9	10	Extreme Pain
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My current pain / problem can be described as: **(check all that apply)**

- Dull  Sharp  Numb  Tightness
- Achy  Stabbing  Tingling  Spasm
- Stiffness  Shooting  Burning  Pressure
- Soreness  Pinching  Other: \_\_\_\_\_



What time of day is the problem worse?  Morning  Mid day  As day progresses  Night  N/A  
 My current pain / problem seems to be:  Getting better  Staying the same  Getting worse  N/A  
 Explain: \_\_\_\_\_

Have you had the same or similar pain/problem in the past?  Yes  No If Yes: How many times? \_\_\_\_\_  
 When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_  
 What treatment have you already received for your condition?  
 Medications  Surgery  Physical Therapy  Chiropractic Care  None How long ago? \_\_\_\_\_  
 Name of other doctor(s) who have treated you for this condition and how: \_\_\_\_\_  
 \_\_\_\_\_  
 Were you satisfied with the results of your treatment?  Yes  No Explain: \_\_\_\_\_  
 \_\_\_\_\_

### Allergies

Are you allergic to any medication(s)?  
 Yes  No If yes, list medications: \_\_\_\_\_  
 \_\_\_\_\_

Other known allergies:  
 Latex  Shellfish  Peanuts  Dairy  
 Other: \_\_\_\_\_  
 Reaction: \_\_\_\_\_

### Smoking History

Do you smoke tobacco of any kind?  
 Yes  Former Smoker  Never been a smoker  
 If yes, how often do you smoke:  
 Current every day  Current sometimes  
 If yes, circle your level of interest in quitting smoking?  
 0 1 2 3 4 5 6 7 8 9 10  
**No interest** **Very Interested**

### Medications

Current medications, including frequency and dosage if known. **If there are no current medications, check here:**

	Medication Name	Quantity/Dosage (i.e. 1 tablet/5 mg)	Frequency (i.e. 2 times/day)	Start Date
1				
2				
3				
4				
5				

**\*\*If you take more medications than you can list above please provide the staff with a full list of medications\*\***  
 Do you currently use any recreational drugs?  Yes  No

### Social History

**WORK ACTIVITY:**  
 What is your job description: \_\_\_\_\_  
 What do you do most of the day at work?  Sitting  Standing  Light Labor  Heavy Labor  Other: \_\_\_\_\_  
 How would you describe the physical stress level at work?  Low  Medium  High

**EDUCATION:**  
 Mark the highest level of education completed:  
 High School  GED  Vocational School  Associates Degree  
 Bachelors Degree  Graduate Degree  Doctorate  Other: \_\_\_\_\_

**DIET / NUTRITION:**

Are you on any special diet?  Yes  No If yes, for what reason: \_\_\_\_\_

Is your weight a concern for you?  Yes  No

Have you gained or lost over 10 pounds in the past 6 months without wanting to?  Yes  No

My dietary intake consists mainly of the following: (check all that apply)

<input type="checkbox"/> Fruits	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Whole Grains	<input type="checkbox"/> High Fiber	<input type="checkbox"/> Low Fiber
<input type="checkbox"/> High Salt	<input type="checkbox"/> Low Salt	<input type="checkbox"/> High Sugar	<input type="checkbox"/> Low Sugar	<input type="checkbox"/> Low Carbohydrate
<input type="checkbox"/> High Fat	<input type="checkbox"/> Low Saturated Fats	<input type="checkbox"/> High Protein	<input type="checkbox"/> Low Protein	<input type="checkbox"/> Low Calorie

How many meals do you eat per day?  Less than 3  3  greater than or equal to 4

How many 8 ounce glasses of water do you drink per day? \_\_\_\_\_

Alcohol Use: Now?  Yes  No If Yes # of drinks/week: \_\_\_\_\_ In the past?  Yes  No If Yes # of drinks/week: \_\_\_\_\_

How many coffee caffeine drinks do you drink a day?  Cups \_\_\_\_\_  None

How many soda/energy drinks do you drink a day?  Cans \_\_\_\_\_  None

Please list any vitamins/supplements you currently take: \_\_\_\_\_

**HEALTH REVIEW:**

How many hours of sleep are you getting per night?  Less than 5  6-8  8-10  10 or more hours

How would you rate your sleep on the following scale?

<b>Wake Fully Rested</b>	0	1	2	3	4	5	6	7	8	9	10	<b>No/Poor Sleep</b>
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How many days a week do you exercise for 30 minutes or more?  0  1-2  3-4  5-6  7

How would you rate the intensity of your exercise?

<b>High Intensity</b>	0	1	2	3	4	5	6	7	8	9	10	<b>No Exercise</b>
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How would you rate your physical stress level?

<b>No Stress</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Very Stressed</b>
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How would you rate your emotional stress level?

<b>No Stress</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Very Stressed</b>
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List your major stressors: \_\_\_\_\_

What are your health goals? \_\_\_\_\_

**In Addition:** Talk to your doctor about other areas which may be affecting your health-such as worries about finances, social support, and alcohol, tobacco and/or drug use.

**Personal Health History**

Are you currently under the care of a Healthcare Provider or any other doctor? Yes No  
If yes, for what condition(s): \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Has any doctor diagnosed you with Hypertension (high blood pressure) recently? Yes No Date Diagnosed: \_\_\_\_\_

Has any doctor diagnosed you with Diabetes recently? Yes No Date Diagnosed: \_\_\_\_\_  
If yes, is your Diabetes under control? Yes No With? Diet Modification Medication Insulin

Has any doctor diagnosed you with any other disease? Describe: \_\_\_\_\_

Do you wear any of the following?  Heel Lefts  Innersoles  Arch Supports  Orthotics  Other: \_\_\_\_\_  
For how long? \_\_\_\_\_ Were they prescribed by a doctor?  Yes  No

Have you seen a chiropractor in the past?  Yes  No Date of last visit: \_\_\_\_\_  
If yes, name and location of previous chiropractor: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
Were you satisfied with your care?  Yes  No Why? \_\_\_\_\_

<b>Date of last:</b>	Chiropractic Exam		Blood Work	
	Spinal X-ray		Mammogram	
	MRI / CT Scan		Pap Smear	
	Bone Density Scan		Prostate / PSA	

**CHILDHOOD ILLNESSES / CONDITIONS:**

<input type="checkbox"/> ADD	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Allergies / Hay fever	<input type="checkbox"/> Chron's / Colitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other: _____

**IMMUNIZATIONS:**

<input type="checkbox"/> All recommended vaccines	<input type="checkbox"/> Influenza	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Adenovirus	<input type="checkbox"/> IPV (polio)	<input type="checkbox"/> Varivax (chicken pox)
<input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis)	<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Haemophilus B	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Not vaccinated
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rotavirus	

**ADULT ILLNESSES:**

<input type="checkbox"/> ADD	<input type="checkbox"/> CRPS (RSD)	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lupus Erythema	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cystic Kidney Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> Shingles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV	<input type="checkbox"/> Pleural Effusion	<input type="checkbox"/> Suicide attempt(s)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Eczema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Colitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Psychiatric Condition	<input type="checkbox"/> Other: _____

**INJURIES: (List date next to injury)**

<input type="checkbox"/> Back injury	<input type="checkbox"/> Fall (severe)	<input type="checkbox"/> Laceration (severe)
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Fracture	<input type="checkbox"/> Motor vehicle accident
<input type="checkbox"/> Disability(ies)	<input type="checkbox"/> Head injury/Concussion	<input type="checkbox"/> Other: _____

**SURGERIES:**

	Date:	Procedure:	Description:	Type: (circle)
1				Inpatient / Outpatient
2				Inpatient / Outpatient
3				Inpatient / Outpatient
4				Inpatient / Outpatient
5				Inpatient / Outpatient

**Family History**

Does anyone in your family suffer with the same or similar condition(s) or any hereditary condition(s)?  Yes  No

If Yes, whom?  Grandmother  Grandfather  Mother  Father  Sister(s)  Brother(s)  Daughter(s)  Son(s)

Please describe the condition(s): \_\_\_\_\_

Have they ever been treated for their condition(s)?  Yes  No  I don't know

Please list any hereditary conditions the doctor should be aware of: \_\_\_\_\_

<b>Review of Symptoms</b>				
<b>Please indicate if you have any of the following by checking the box.</b>				
Constitutional	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Chills	<input type="checkbox"/> Daytime drowsiness <input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever <input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Night sweats <input type="checkbox"/> Weight gain / loss
Eyes / Vision	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Blindness	<input type="checkbox"/> Cataracts <input type="checkbox"/> Double vision	<input type="checkbox"/> Itching <input type="checkbox"/> Photophobia	<input type="checkbox"/> Wear contacts/glasses <input type="checkbox"/> Eye problems
Ears, Nose, & Throat	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Ear discharge	<input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinus infection	<input type="checkbox"/> Loss of sense of smell <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Frequent sore throats <input type="checkbox"/> History of head injury <input type="checkbox"/> Fainting
Respiration	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Asthma	<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sputum production	<input type="checkbox"/> Wheezing
Cardiovascular	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Claudication (leg pain and ache)	<input type="checkbox"/> Heart murmur <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Palpitations/Arrythmia <input type="checkbox"/> Orthopnea (difficulty breathing lying down)	<input type="checkbox"/> Shortness of breath with exertion <input type="checkbox"/> Varicose veins
Gastrointestinal	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abnormal stool (color/consistency)	<input type="checkbox"/> Belching <input type="checkbox"/> Black/tarry stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion	<input type="checkbox"/> Jaundice <input type="checkbox"/> Ulcers <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Loss of bowel control
Female	<input type="checkbox"/> <b>None/NA</b> <input type="checkbox"/> Abnormal vaginal bleeding <b>Pregnancy status:</b> <b>Menses:</b>	<input type="checkbox"/> Breast lump/pain <input type="checkbox"/> Burning with urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Currently have menses <input type="checkbox"/> Are regular	<input type="checkbox"/> Birth control <input type="checkbox"/> Irregular menstruation <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> NOT currently pregnant <input type="checkbox"/> Currently DO NOT have menses <input type="checkbox"/> Are NOT regular	<input type="checkbox"/> Urine retention/incontinence <input type="checkbox"/> Cramps
	Date of last menstrual period: ____/____/____ If you have been pregnant in the past, please fill in the appropriate information below: ____ Number of pregnancies                      ____ Number of deliveries ____ Number of vaginal deliveries                      ____ Number of C-sections			
Male	<input type="checkbox"/> <b>None/NA</b> <input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Burning with urination <input type="checkbox"/> Hesitancy/dribbling	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Prostate problems	<input type="checkbox"/> Urine (Retention/Incontinence)
Sexual Health	Do you have any concerns about your sexual health? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you or have you ever been a victim of domestic or sexual abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Skin	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Change in nail texture <input type="checkbox"/> Change in skin color	<input type="checkbox"/> Hair loss <input type="checkbox"/> Hives <input type="checkbox"/> Skin disorders	<input type="checkbox"/> Itching <input type="checkbox"/> Numbness <input type="checkbox"/> Rash	<input type="checkbox"/> Skin lesions/ulcers <input type="checkbox"/> Varicosities
Nervous System	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Stress	<input type="checkbox"/> Facial weakness <input type="checkbox"/> Limb weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Concussion	<input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Slurred speech	<input type="checkbox"/> Unsteadiness of gait/loss of balance <input type="checkbox"/> Sleep disturbance
Psychological	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Behavioral change	<input type="checkbox"/> Bi-polar disorder <input type="checkbox"/> Confusion <input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Mood change	<input type="checkbox"/> Memory loss <input type="checkbox"/> Loss or change of appetite <input type="checkbox"/> Panic attacks
Hematologic	<input type="checkbox"/> <b>None</b> <input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding <input type="checkbox"/> Blood clotting	<input type="checkbox"/> Blood transfusion <input type="checkbox"/> Bruising easily	<input type="checkbox"/> Fatigue <input type="checkbox"/> Lymph node swelling

Please check the appropriate response. If you are not sure then check the “?” box.

No	Yes	?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a past history of cancer?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any unexplained weight loss?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Your pain does NOT improve with rest?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you over 50 years old?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failure to respond to a course of conservative care (4-6 weeks)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of significant trauma?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minor trauma in person > 50 years old?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have osteoporosis (weak bones)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you over 70 years old?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any history or prolonged user of corticosteroids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acute onset of urinary tract retention or overflow incontinence (wet underwear)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saddle anesthesia (numbness in the groin region)?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Global or progressive muscle weakness in the legs (legs give out)?

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my Chiropractic evaluation at Ascherl Chiropractic Sports & Wellness Clinic.

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Patient (or Authorized Person) Signature

Relationship to patient

Date

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Doctor's Signature

Date Reviewed