

APPLICATION FOR ACCEPTANCE AS A PATIENT AT FIVE STAR CHIROPRACTIC CENTER

Name _____ SS# _____ Date of birth _____ Age _____

Street Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail _____ Height _____ Weight _____

Employer _____ Wk phone _____ Occupation _____

Male Female Single Married # of children _____ Name of spouse (or parent) _____

Who referred you to our clinic? _____ Yellow Pages Mailing Newspaper _____

Reasons for today's visit (please list your main complaints in order of severity - pain, symptoms, etc.):

1. _____ For how long? _____ getting worse staying the same

2. _____ For how long? _____ getting worse staying the same

3. _____ For how long? _____ getting worse staying the same

Who is your primary doctor? _____ City _____

A report on your condition, x-ray and MRI findings and updates will be submitted to the above doctor unless you check this box do not submit reports to my doctor.

Please check the conditions you suffer from currently or in the past.

Allergies Headaches Joint Pain Sinus Problems
 Arthritis Migraines Muscle Pain Digestive Problems
 Asthma Dizziness Numbness & Tingling Blood Pressure Problems
 Fatigue Scoliosis Carpal Tunnel Pain Bowel Problems
 Stress Jaw Pain Fertility Problems Ear Pain/Infections
 Sleep Disturbances Menstrual Cramps Mood swings/Irritability Hyperactive Disorders

Please list any injuries or illnesses that you have had that are not listed above _____

Previous Surgeries _____

Medications you are taking (prescriptions and over the counter: Aspirin/Tylenol Pain killers Muscle Relaxers Other _____

Is your pain the result of an auto accident in the last 12 months? Yes No If yes, date of accident _____ # of passengers _____

Date of most recent Spinal X-rays _____ Performed at _____

Date of most recent Spinal MRI _____ Performed at _____

Have you ever had:

Bones in your lower back surgically fused?	YES	NO	Cancer?	YES	NO
Aortic aneurysm?	YES	NO	Surgery on your spine?	YES	NO

Fracture of your back or neck?

YES NO Paralyzed legs or arms?

YES NO

Date of last chiropractic visit (approximate) _____ Name of Chiropractor _____

Insurance Information: (Please give your insurance card to the receptionist after providing the information below.)

Health Insurance Co. Name _____ Policy Number _____

Name of Secondary Health Insurance (If applicable) _____ Policy Number _____

Our Satisfaction Guarantee:

Since results vary, we cannot guarantee results, but we can promise your satisfaction. If within 7 days you are not completely happy with your decision to begin care at our clinic, we will happily refund the money you have paid us.

I agree to be responsible for timely payment of services rendered to me by Five Star Chiropractic Center. I certify that I (or my dependent) have insurance coverage with the companies named above and assign directly to Five Star Chiropractic Center all insurance benefits for services rendered. I authorize Five Star Chiropractic Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

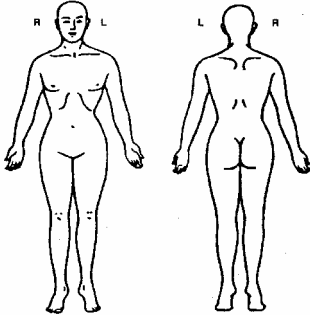
Patient's Signature _____ Date _____

Name _____ Date _____

On a scale of 1-10 how would you rate your pain intensity (1 = minimal; 10 = severe/debilitating)? _____

Describe your current condition/symptoms.

Please circle your area(s) of pain below.



When did your present condition begin?

- Date _____
- Gradual onset (no specific date)

What caused your present condition?

- Auto accident Home accident
- Work accident No specific injury

What happened to cause your present pain?

Have you ever had these symptoms before?

- Yes (Date _____)
- No

What time of day are your symptoms better?

- Morning
- Afternoon
- Evening
- None of the above (constant pain)

What time of day are your symptoms worse?

- Morning
- Afternoon
- Evening
- None of the above (constant pain)

What makes your pain better?

- Rest
- Ice
- Heating pad/Hot tub
- Prescription medications _____
- Over the counter medications _____
- Other _____
- Sitting
- Standing
- Lying Down

What makes your pain worse?

- Ice
- Heating pad/Hot tub
- Driving or riding in a car
- Certain activities _____
- Other _____
- Sitting
- Standing
- Lying Down

What home remedies have you tried?

- Ice packs
- Heating pad/Hot tub
- Other _____
- Exercise
- Stretching

Have you missed any work due to this condition?

- Yes (Dates _____)
- No

Please check the aspects of your life that are presently disrupted by your current health condition.

- FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, washing dishes, errands, driving children to school, etc.)
- SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.
- OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs, such as that of a homemaker or volunteer worker.
- SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)
- LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing.

Doctor's Notes: