Charlotte Health Center – NEW PATIENT APPLICATION

Whom may we thank for referring you to our office? ___________________________________ Today's Date: ____________________
HR#: ___________________________

PATIENT DEMOGRAPHICS:

Name: ____ Birth Date: _____-_____-_____ Age: ________ ❑ M ❑ F
Address: ____ City: _______________________ State: _______ Zip: _________
Email: ____ Mobile#: ____
Home#: ____ Work#: ____
Work#: ____ Fax#-Home or Work: _______________________________________
Driver's License#: ___________________________________ Social Security #____
Employer: ____ Occupation: ____
Name of Spouse: ____________________________________
Spouse's Employer: __________________________________ Spouse's Occupation: ____
Names & Ages of Children: ____
Emergency Contact Name: __________________________Relationship: __________________Number _____________________

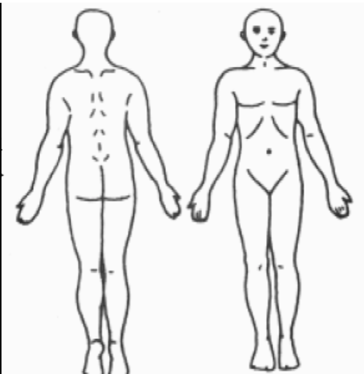
HISTORY OF COMPLAINT:

1. Please identify the condition(s) that brought you to our office: Primary: ____
   Secondary: ____________________________ 3rd: ____________________________ 4th: ______________________________
2. If symptom is painful rate your above complaints, by circling the number on a scale of 0-10 (10=worst pain and 0=no pain):
   Primary Complaint: 0 1 2 3 4 5 6 7 8 9 10 Secondary Complaint: 0 1 2 3 4 5 6 7 8 9 10
   3rd Complaint: 0 1 2 3 4 5 6 7 8 9 10 4th Complaint: 0 1 2 3 4 5 6 7 8 9 10
3. When did the complaint(s) begin? __________________ When is the complaint(s) the worst? ❑ AM ❑ Mid-Day ❑ PM
4. How did the "injury" (complaint) happen? ____
5. How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week
6. What relieves your symptoms? ______________________ What makes it feel worse? ___________________________________
7. Condition(s) treated in the past? ❑ No ❑ Yes – If yes, when? ____________ By whom? _________________________________
8. How long were you under care? _____________________ What were the results? _____________________________________
9. Name of Previous Chiropractor: ____________________________________ Location: ___________________________________
10. **What is your motivation for wanting to become healthy?** ____

____

LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
______________________	_______________________	_____________________
______________________	_______________________	_____________________
______________________	_______________________	_____________________

Is your problem/complaint the result of ANY type of accident? ❑ No ❑ Yes
Identify any other injury(s) minor or major, that the Doctor should know about?:



DESCRIBE YOUR SYMPTOMS: **PLEASE MARK the areas on the diagram with the following LETTERS:**

R = Radiating **B =** Burning **D =** Dull **A =** Aching **N =** Numbness **S =** Sharp/Stabbing **T =** Tingling

PAST HISTORY:

1. 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? ______________________________

2. 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: ____

3. Please identify any and all types of jobs you have had that have imposed any physical stress on you or your body:
   ____

4. If you have ever been diagnosed with any of the following conditions, please indicate with a **P** (past), **C** (current) or **N** (never):
   ❑ Broken Bone ❑ Dislocations ❑ Tumor ❑ Rheumatoid Arthritis ❑ Fracture ❑ Disability
   ❑ Cancer ❑ Heart Attack ❑ Osteo Arthritis ❑ Cerebral Vascular ❑ Other serious conditions

5. Please, identify ALL PAST and CURRENT conditions you feel may be contributing to your present complain:

	HOW LONG AGO?	TYPE OF CARE RECEIVED?	BY WHOM?
INJURIES >>	__________________________	>> ________________________	>> ___________________________________
SURGERIES >>	________________________	>> _________________________	>> ___________________________________
CHILD DISEASES >>	____________________	>> _________________________	>> ___________________________________
ADULT DISEASES >>	____________________	>> _________________________	>> ___________________________________

SOCIAL HISTORY:

1. Smoking: ❑ Cigars ❑ Pipe ❑ Cigarettes >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverages (Consumption): >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug Use: >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? __________________________
   ____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same complaint(s)? ❑ No ❑ Yes
   If Yes, whom? ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Son ❑ Daughter

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

3. Any other hereditary conditions the Doctor should be aware of? ❑ No ❑ Yes: ____

FEMALES ONLY → *please read carefully, and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on: ______________ (Date)

☐ I have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination if the doctor has deemed necessary in my case.

____________________________________ _______________ *Witness Initials*

Patient or Authorized Person's Signature Date

ACTIVITIES OF DAILY LIVING
(SYMPTOMS/MEDICATIONS)

Patient Name: ____ Date: _______________________

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:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently have, and N for Never:

___Headache
___Neck Pain
___Jaw Pain, TMJ
___Shoulder Pain
___Upper Back Pain
___Mid Back Pain
___Low Back Pain
___Hip Pain
___Pregnant (now)
___Dizziness
___Prostate Problems
___Ulcers
___Frequent Colds/Flu
___Loss of Balance
___Impotence/Sexual Dysfun.
___Heartburn
___Convulsions/Epilepsy
___Fainting
___Digestive Problems
___Heart Problem
___Shoulder Pain
___Tremors
___Double Vision
___Colon Trouble
___High Blood Pressure
___Chest Pain
___Blurred Vision

___Diarrhea/Constipation
___Low Blood Pressure
___Pain w/Cough/Sneeze
___Ringing in Ears
___Menopausal Problems
___Asthma
___Foot or Knee Problems
___Hearing Loss
___Menstrual Problem
___Difficulty Breathing
___Sinus/Drainage Problem
___Depression
___PMS
___Lung Problems
___Back Curvature
___Swollen/Painful Joints
___Irritable
___Bed Wetting
___Kidney Trouble
___Scoliosis
___Skin Problems
___Mood Changes
___Learning Disability
___Gall Bladder Trouble
___Numb/Tingling arms, hands, fingers
___ADD/ADHD
___Eating Disorder

___Liver Trouble
___Numb/Tingling legs, feet, toes
___Allergies
___Trouble Sleeping
___Hepatitis (A,B,C)

List Prescription & Non-Prescription medications you take:

____
____
____
____
____
____

INITIAL HEALTH PROFILE

Patient Name: ____ Today's Date: ___________________

INITIAL NERVE SYSTEM PROFILE:

1. What was your most recent auto accident? ____
   a. What speed was the collision? ____
   b. Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact
   c. Was treatment received? ❑ No ❑ Yes – If yes, please describe: _______________________________________
2. When was your most recent strain/stress at work? ____
   a. Please describe the manner of the injury: ____
   b. Was treatment received? ❑ No ❑ Yes – If yes, please describe: _______________________________________
   c. Does your job require you to remain in long-term stressful postures? ❑ No ❑ Yes
      (*i.e. all day seating, repeated lifting, long-term computer use)*
3. Any spinal traumas in the past? ❑ No ❑ Yes – If yes, please describe: ____
   a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field ____
   b. Trauma as a child: (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident) ____
   c. Work around the house: (lifting, bending, woke up with stiff neck, "back went out") ______________________
      ____

INITIAL NUTRITIONAL PROFILE:

1. Have you tested with high triglycerides or high cholesterol? ❑ No ❑ Yes – If Yes, Values: ______________________________
2. Have you tested with high blood pressure? ❑ No ❑ Yes
3. Are you diabetic? ❑ No ❑ Yes
4. Have you been diagnose as pre-diabetic or with metabolic syndrome? ❑ No ❑ Yes
5. Do you eat breakfast daily from Monday to Friday? ❑ No ❑ Yes
6. How many days per week do you skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4+
7. How many fast food, refined foods, or pre-pared meals do you eat per week? ❑ 0 ❑ 1-3 ❑ 4-6 ❑ 7+
8. How many servings of fruit do you have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4+
9. How many servings of vegetables do you have on a given day? ❑ 0-1 ❑ 2-3 ❑ 4-5
10. Do you regularly drink (1 or more per day) any of the following? (circle all that apply)
    ❑ Diet Soda/Pop ❑ Coffee ❑ Juice ❑ Milk ❑ Soda ❑ Alcohol
11. Please list any supplements you take regularly: ____

INITIAL FITNESS PROFILE:

1. How many times per week do you exercise? ____
2. Cardiovascular: ______Hours   ______Days per Week
3. Weight Training: ______Hours   ______Days per Week
4. Low Impact (yoga, etc.): ______Hours   ______Days per Week
5. What is your target weight? _________
6. What is your current weight? __________
7. How willing are you to change any of these things to reach your health goals? (Scale of 1-10) ____________

INITIAL TOXICITY PROFILE:

1. Are you regularly exposed to cleaning products or industrial chemicals? ❑ No ❑ Yes
2. Have you ever noticed mold growing in your home or your place of work? ❑ No ❑ Yes
3. Does your home, work, school, or car have damp or mildew smell? ❑ No ❑ Yes
4. Have you received a full standard profile of vaccinations? ❑ No ❑ Yes
5. Do you receive yearly flu shots? ❑ No ❑ Yes – If Yes, How many have you received? _________ (estimate)
6. Have any members of your family been diagnosed with fibromyalgia, chronic fatigue, or multiple chemical sensitivities? ❑ No ❑ Yes
7. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ❑ No ❑ Yes

INITIAL STRESS PROFILE:

1. Do you get an average of 8 hours of sleep per night? ❑ No ❑ Yes
2. Do you average less than 7 hours of sleep per night? ❑ No ❑ Yes
3. Do you ever take pills to go to sleep or relax? ❑ No ❑ Yes
4. Do you often feel short on time and procrastinate on projects? ❑ No ❑ Yes
5. Do you experience feelings of anxiety about completing tasks? ❑ No ❑ Yes
6. Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? ❑ No ❑ Yes
7. Do you rely more on your memory than a planner and action list to get things done? ❑ No ❑ Yes
8. Do you take time to pray, meditate, or visualize on a regular basis? ❑ No ❑ Yes

Doctor's Signature: ____   **Date: ___________________________________**

INFORMED CONSENT

Patient Name: ____ Today's Date: ___________________

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Charlotte Health Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Charlotte Health Center will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Life Charlotte Health Center have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ _______________ *Witness Initials*

Patient or Authorized Person's Signature Date

Notice of Privacy Practice

I have read the office Patient Privacy Notice, which was handed to me and is also located in the notebook in the waiting room. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ _______________ ___________________________

Patient's Name (Printed) DOB HR#:

____ _______________

Patient's Signature Date

____ _______________

Witness's Signature Date