

# Application for Care



*Brouse Wellness Chiropractic*

FIRST NAME \_\_\_\_\_ M \_\_\_\_\_ LAST \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
 E-MAIL \_\_\_\_\_  
 MY GOAL FOR CONSULTING WITH THE DOCTOR:  Temporary Relief  
 Lasting Correction  Let Doctor Recommend The Best Type Of Care For You

SS# \_\_\_\_\_ DRIVER LICENSE # \_\_\_\_\_  
 DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ MARITAL STATUS **S D W M**  
 SPOUSE'S NAME: \_\_\_\_\_ # OF CHILDREN \_\_\_\_\_  
 SPOUSE'S OCCUPATION \_\_\_\_\_  
 SPOUSE'S EMPLOYER \_\_\_\_\_  
 EMERGENCY CONTACT \_\_\_\_\_  
 PHONE \_\_\_\_\_ REFFFERED BY: \_\_\_\_\_

If female, are you **pregnant**? \_\_\_\_\_ If yes let the front desk know and she will get you our pregnancy application for care form.  
 If you had a recent **car accident or work injury** tell the front desk and she will get you the appropriate form for this type of injury.

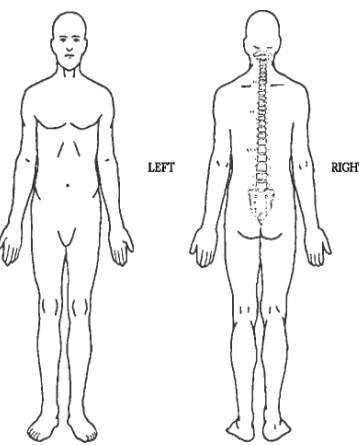
**Major Complaint(S):** \_\_\_\_\_  
 On A Scale of 1-10 How Committed Are You To Getting Rid Of This Problem. (0= Not Committed 10= Totally Committed) \_\_\_\_\_  
 What caused it? How did it start? (Gradual/Injury) \_\_\_\_\_  
 When was the first time you became aware of this problem? (How long have you had it?) \_\_\_\_\_  
 Have you had these symptoms before (105):  NO  YES When? \_\_\_\_\_  
 Are your symptoms:  Improving (101)  About the same (102)  Getting Worse (103)  Intermittent (come and go) (104)  
 Medications you are on now (108): \_\_\_\_\_  
 Social Habits (114):  Tobacco  Alcohol  coffee  
 Exercise (115):  no exercise program  light exercise  moderate exercise  strenuous exercise  
 Stress levels (116):  little or no  minimal  moderate  greatly-stressed  
 What activity would you like to be able to do again that is difficult or that you cannot do now? \_\_\_\_\_  
 Physical Activity (117):  sitting 50% or more  light labor  manual labor  heavy labor  repeated motion

**CHECK THOSE ACTIVITIES BELOW DURING WHICH YOU EXPERIENCE DIFFICULTY** (15 36)

- |  |  |                                   |   |   |
|--|--|-----------------------------------|---|---|
| <input type="checkbox"/> Lying on back                 | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Stooping         | <input type="checkbox"/> Standing for periods over one hour |
| <input type="checkbox"/> Lying on side with knees bent | <input type="checkbox"/> Gripping              | <input type="checkbox"/> Pushing  | <input type="checkbox"/> Sitting          | <input type="checkbox"/> Sneezing                           |
| <input type="checkbox"/> Turning over in bed           | <input type="checkbox"/> Climbing              | <input type="checkbox"/> Pulling  | <input type="checkbox"/> Bending forward  | <input type="checkbox"/> Sweeping/Mopping                   |
| <input type="checkbox"/> Lying flat on Stomach         | <input type="checkbox"/> Dressing self         | <input type="checkbox"/> Reaching | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Washing Dishes                     |
|  | <input type="checkbox"/> Sexual activity       | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Walking          | <input type="checkbox"/> Working                            |
|  | <input type="checkbox"/> Bathing/Showering     | <input type="checkbox"/> Shaving  | <input type="checkbox"/> Cleaning         |   |

**Please check all additional complaints that you have at this time:** (118)

Please mark your areas of pain on the figure  
 A = Ache B = Burn N = Numbness  
 S = Sharp D = Dull P = Pins & Needles  
 Rate Severity 1-10 \_\_\_\_\_



- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Headache                | <input type="checkbox"/> Neck Stiffness                 | <input type="checkbox"/> Cold Feet                     |
| <input type="checkbox"/> Irritable             | <input type="checkbox"/> Loss of Concentration   | <input type="checkbox"/> Neck Motion Restricted         | <input type="checkbox"/> Jaw Pain                      |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Upper Back Pain/Stiffness      | <input type="checkbox"/> Cancer                        |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Memory Loss             | <input type="checkbox"/> Mid Back Pain/Stiffness        | <input type="checkbox"/> Hypertension                  |
| <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Heavy Feeling of Head   | <input type="checkbox"/> Lower Back Pain/Stiffness      | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Right/Left Shoulder Pain       | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> Flushed Face          | <input type="checkbox"/> Ringing in Ears         | <input type="checkbox"/> Right/Left Arm Pain            | <input type="checkbox"/> Convulsions                   |
| <input type="checkbox"/> Excess Perspiration   | <input type="checkbox"/> Loss of Balance         | <input type="checkbox"/> Right/Left Leg Pain            | <input type="checkbox"/> Allergies (Please List) _____ |
| <input type="checkbox"/> Digestive             | <input type="checkbox"/> Loss of Smell           | <input type="checkbox"/> Pins & Needles Arms/Legs _____ |  |
| <input type="checkbox"/> Nausea                | <input type="checkbox"/> Loss of Taste           | <input type="checkbox"/> Vision Problems _____          |  |
| <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Pain behind Eyes        | <input type="checkbox"/> Sinus Trouble _____            |  |
|  | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Nervousness _____              | <input type="checkbox"/> Anemia _____                  |
|  |  | <input type="checkbox"/> Chest Pain _____               |  |

List all surgical operations (107)? \_\_\_\_\_  
 When did you last see a Chiropractor? \_\_\_\_\_  
 Name of family doctor (106)? \_\_\_\_\_  
 Previous Treatment for this type of problem: \_\_\_\_\_  
 What spinal hygiene rituals do you practice: \_\_\_\_\_

What have you heard about chiropractic care? \_\_\_\_\_  
 Do you know what a subluxation is? If yes please describe: \_\_\_\_\_  
 Have you ever been diagnosed with cancer? \_\_\_\_\_ If so, what type? \_\_\_\_\_

The above information is true and accurate to the best of my knowledge. My reason for an assessment with the doctor is for evaluation of my physical health and potential for improvement. Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_