T 1 2 3

ANCHOR HEALTH CHIROPRACTIC

In:_____

NEW PRACTICE MEMBER APPLICATION

Name_____**Date of Birth**____ /_____ /_____**Age**_____**Male/Female**

Address_____**City**_____**State**_____**Zip**_____

Phone: Cell_____**Home**_____**Cellular Provider**_____

Email Address_____

Occupation_____**Employer's Name**_____

Single / Married / Divorced / Widowed **Spouse's Name**_____

Number of Children_____ **Names, Ages & Gender**_____

Who may we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concern: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	_____
Second:_____	_____	_____	_____	_____	_____
Third:_____	_____	_____	_____	_____	_____
Fourth:_____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____**MEDICAL DOCTOR?**_____**OTHER**_____

WHO AND WHEN?_____

WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain) _____

_____

PLEASE MARK "P" FOR IN THE PAST, OR MARK "C" FOR CURRENTLY HAVE:

___ *Headaches*	___ *Ear Infections*	___ *Sinus Issues*	___ *Kidney Problems*	___ *Sexual Dysfunction*
___ *Migraines*	___ *Hearing Loss*	___ *Frequent Colds*	___ *Bladder Problems*	___ *Sleep Problems*
___ *Jaw/TMJ Pain*	___ *Ringing in the Ears*	___ *Thyroid Issues*	___ *Menstrual Problems*	___ *Tight/Sore Muscles*
___ *Neck Pain*	___ *Dizziness*	___ *Asthma*	___ *Prostate Problems*	___ *Sports Injury*
___ *Shoulder Pain*	___ *Loss of Energy*	___ *Chest Pain*	___ *Infertility*	___ *Sciatica*
___ *Arm Pain*	___ *Nervousness*	___ *Heart Problems*	___ *Fibromyalgia*	___ *Arthritis/Joint Pain*
___ *Upper Back Pain*	___ *Double/Blurry Vision*	___ *Nausea*	___ *Epilepsy/Convulsions*	___ *GERD/Gastric Reflux*
___ *Mid Back Pain*	___ *Anxiety*	___ *Ulcers*	___ *Tremors*	___ *Numb/Tingling in Arms/Hand*
___ *Lower Back Pain*	___ *ADD/ADHD*	___ *Digestive Issues*	___ *Disc Problems*	___ *Numb/Tingling in Legs/Feet*
___ *Hip/Leg Pain*	___ *Loss of Balance*	___ *Diarrhea*	___ *Scoliosis*	___ *Stomach Problems*
___ *Knee Pain*	___ *Depression*	___ *Constipation*	___ *Poor Posture*	___ *High/Low Blood Pressure*
___ *Foot Pain*	___ *Allergies*	___ *Bed Wetting*	___ *Skin Problems*	___ *Difficulty Breathing*

*Other:*_____

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PLEASE MARK "P" FOR IN THE PAST, OR MARK "C" FOR CURRENTLY HAVE:

___STROKE ___ CANCER ___HEART ATTACK ___SPINAL SURGERY ___SEIZURES ___SPINAL BONE FRACTURE ___SCOLIOSIS
___DIABETES ___OSTEOARTHRITIS ___RHEUMATOID ARTHRITIS ___OTHER CONDITIONS/DISEASES

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT?_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YOU HAVE, DR. & DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES TO EITHER OF THE ABOVE, PLEASE DESCRIBE:_____

OTHER TRAUMA:_____

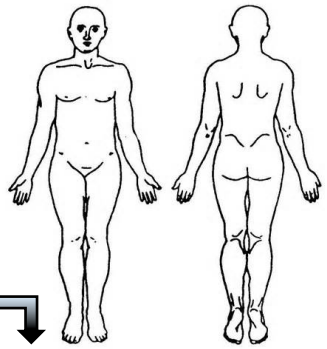
_____

SOCIAL HISTORY

1. SMOKING: How often? □ Daily □ Weekends □ Occasionally □ Never
2. ALCOHOL: How often? □ Daily □ Weekends □ Occasionally □ Never
2. EXERCISE: How often? □ Daily □ Weekends □ Occasionally □ Never
3. How does your present problem affect the following: HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE

_____
_____

***PLEASE MARK** the areas on the diagram with the following **LETTERS** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling



What relieves your symptoms?_____
What makes them feel worse?_____

List Your Current Health Goals Below

HEALTH GOAL	DATE TO ACCOMPLISH	SIGNIFICANCE OF GOAL
Ex: Get rid of my headaches	**1/1/2016**	**I want to play with my kids without pain, be able to spend more time with my family and have more energy.**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

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ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Signature: _____ Date____ /_____ /_____

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QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

No pain _____ Worst possible pain

0 1 2 3 4 5 6 (7) 8 9 10

1. How would you rate your pain RIGHT NOW?

_____

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

_____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1____+Q2____+Q4____=____/3x10=____ (Low Intensity = <50; High Intensity = >50)