NEW PRACTICE MEMBER INTAKE

rising CHIROPRACTIC

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ **Nickname** _____

Address _____

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

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ **Phone Number** _____

Your Occupation _____ **Retired?** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ Neck Pain	☐ Pacemaker/ Defibrillator	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Implanted Cord/ Bladder Stimulator	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disc	☐ Morton's Neuroma	☐ Sciatica	☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better or worse?

_____

_____

_____

_____

List the things you have used for these problems:

Gabapentin ☐ *Neurontin* ☐ *Lyrica* ☐ *Cymbalta* ☐ *Tylenol* ☐

Physical Therapy ☐ *Pain Medications* ☐ *Aleve* ☐ *Ibuprofen* ☐

Motrin ☐ *Chiropractic* ☐ *Massage* ☐ *Therapy* ☐ *Injections* ☐ *Creams* ☐

Is your balance/walking ability affected?
If yes, please describe:

_____

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

_____

Name of all doctors you have seen for these problems and treatment you received:

_____

NEW PRACTICE MEMBER INTAKE

rising CHIROPRACTIC

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe type & how often: _____

_____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ WORST PAIN POSSIBLE

NEW PRACTICE MEMBER INTAKE

rising CHIROPRACTIC

PREVIOUS HEALTH HISTORYHEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ ***Signature*** _____

Please give name, address, and office phone number of your primary care physician.

Name _____ ***Phone*** _____ ***Address*** _____

When were you last seen there?

_____

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	*Reaction:*

List the prescription drugs you are currently taking (or you may attach a list):

Name	*Dose (mg or IU)*	*Times Daily*

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

Quality Of Life Survey

rising CHIROPRACTIC

Rising Chiropractic

Practice Member Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take a few minutes to answer these questions about how your health issue is affecting your life. This information is important to providing you the best possible care.

(Please choose all that apply)

1 How have you taken care of this health issue in the past?

- **a.** Medications ☐
- **b.** Emergency Room ☐
- **c.** Routine Medical ☐
- **d.** Exercise ☐
- **e.** Nutrition/Diet ☐
- **f.** Holistic Care ☐
- **g.** Vitamins ☐
- **h.** Chiropractic ☐
- **i.** Other (please specify): _____

2 How did the previous method(s) work out for you?

- **a.** Bad results ☐
- **b.** Some results ☐
- **c.** Great results ☐
- **d.** Nothing changed ☐
- **e.** Did not get worse ☐
- **f.** Did not work very long ☐
- **g.** Still trying ☐
- **h.** Confused ☐

3 How have others been affected by your health condition?

- **a.** No one is affected ☐
- **b.** Haven't noticed any problem ☐
- **c.** They tell me to do something ☐
- **d.** People avoid me ☐

4 What are you afraid this might be (or beginning) to affect (or will affect)?

- **a.** Job ☐
- **b.** Kids ☐
- **c.** Future ability ☐
- **d.** Marriage ☐
- **e.** Self-esteem ☐
- **f.** Sleep ☐
- **g.** Time ☐
- **h.** Finances ☐
- **i.** Freedom ☐

Quality Of Life Survey

rising CHIROPRACTIC

5 Are there health conditions you are afraid this might turn into?

- a. Family health problems ☐
- b. Heart disease ☐
- c. Cancer ☐
- d. Diabetes ☐
- e. Arthritis ☐
- f. Fibromyalgia ☐
- g. Depression ☐
- h. Chronic Fatigue ☐
- i. Need surgery ☐

How has this health condition affected your job, relationships, finances, family, or other activities? Please give examples:

1.
2.
3.
4.

What has that cost you? (i.e. time, money, happiness, freedom, sleep, promotion, etc.) Give 3-4 examples:

1.
2.
3.

What are you most concerned with regarding this problem?

Where do you picture yourself being in the next 5 years, *if this problem is not taken care of? Please be specific.*

What would be different/better without this problem? Please be specific.

What do you desire most to get from working with us (i.e GOALS for care)?

What would that mean to you?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
- Headaches and migraines

Hormone imbalance including:
- PMS
- Emotional imbalance

Gastrointestinal issues including:
- Abdominal bloating and cramps or painful gas
- Irritable Bowel Syndrome
- Ulcerative Colitis
- Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
- Chronic sinusitis
- Asthma
- Allergies

Autoimmune Conditions including:
- Diabetes Mellitus
- Lupus
- Rheumatoid Arthritis
- Fibromyalgia
- Chronic Fatigue

Developmental and social concerns including:
- Austism
- ADD/ADHD

Skin Conditions: (urticaria)
- Eczema
- Skin rashes
- Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	☐	☐	☐	☐
Abdominal pain or bloating	☐	☐	☐	☐
Mucous or blood in stool	☐	☐	☐	☐
Joint pain or swelling, arthritis	☐	☐	☐	☐
Chronic or frequent fatigue or tiredness	☐	☐	☐	☐
Food allergies, sensitivities or intolerance	☐	☐	☐	☐
Sinus or nasal congestion	☐	☐	☐	☐
Chronic or frequent inflammations	☐	☐	☐	☐
Eczema, skin rashes or hives (urticaria)	☐	☐	☐	☐
	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	☐	☐	☐	☐
Confusion, poor memory or mood swings	☐	☐	☐	☐
Use of NSAIDS (Aspirin, Tylenol, Motrin)	☐	☐	☐	☐
History of antibiotic use	☐	☐	☐	☐
Alcohol consumption makes you feel sick	☐	☐	☐	☐
Ulcerative colitis or celiac's disease	☐	☐	☐	☐
Nausea	☐	☐	☐	☐
Weight Trouble	☐	☐	☐	☐
	0	1	2	3

YOUR TOTAL: _____