GORDON CHIROPRACTIC
Family Health and Wellness Center
3212 N 13th St.
Terre Haute IN 47804
(812) 460-1400 Phone
www.gordon-chiro.com

Please complete this application for care to help us determine if chiropractic care is right for you.

PERSONAL HISTORY

Today's date:

Name: _____ ☐ M ☐ F Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Marital Status: M S W D Spouse's Name: _____ Spouses DOB: _____

# of Children: _____ Name of Primary Care Physician: _____

Physician's Phone: _____ Date of last visit: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Have you previously been seen by a Chiropractor? ☐ Yes ☐ No Who/When? _____

How did you hear about our office? (circle one) Friend or Family Facebook Website TV Radio Phone Book Other

Please name the person who referred you so that we may thank them: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy/ID #: _____

Social Security Number: _____

ASSIGNMENT OF BENEFITS

I certified that I, and/or my dependent(s), have insurance coverage and assign directly to Gordon Chiropractic all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Any outstanding balances over 90 days are subject to being turned over to Professional Accounts Service, INC and will be charged at 40% collection fee in addition to the balance due.

I authorize the use of my signature on all insurance submissions. I further authorized Gordon Chiropractic to use my healthcare information and disclose information to your insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I am also informed at this time I have the right to withdraw my name from this signature on file agreement at any time when I have notified this office in writing. In the case that the patient is a minor I as the guardian am stating that I agree for Gordon Chiropractic to provide all services of care to my minor child/children.

Patient/Guardian Signature: _____ Date _____

Throughout life, stressed and traumatic events can damage the spine and nervous system. These stresses may be PHYSICAL, CHEMICAL, and/or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous assists us in serving you.

HISTORY OF PHYSICAL STRESS

Have you EVER had any accidents related to the following: (check all that apply, explain and give dates)

☐ Auto ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Other: If yes, explain: _____

_____

Have you EVER been in a fender bender or minor car accident? ☐ Yes ☐ No Please list date(s): _____

_____

Have you ever injured your nerve system or spine (head, neck, back, hips, pelvis) ☐ Yes ☐ No If yes, explain: _____

_____

Have you broken any bones? ☐ Yes ☐ No Sprained any part of the body? ☐ Yes ☐ No

If yes, location, date, and how: _____

Surgical history: _____

Hospitalization history: _____

Hobbies or interests: _____ Daily/Work activities (circle): sit stand lift bend twist

Do you exercise? ☐ Yes ☐ No Type/frequency: _____

HISTORY OF CHEMICAL STRESS

Chemical stresses occur during life due to any substance that is inhaled, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposure you might have had or currently have.

Have you EVER used prescription or recreational drugs or been vaccinated? ☐ Yes ☐ No

List all medication (prescription and over the counter) and vitamins you take and why: _____

_____

_____

FEMALES: Pill or Patch Use? ☐ Yes, currently for the last _____ years ☐ No, but previously for _____ year ☐ Never

SMOKER? ☐ Never ☐ Yes, currently ☐ Yes, previously, but quit _____ (date) Packs per day? _____

How many servings of fresh fruits/vegetables do you eat in a typical day? _____ Caffeine? _____ cup/day

How many glasses of water do you drink each day? _____

HISTORY OF EMOTIONAL STRESS

It is difficult to separate the emotional stress in our lives from the physical response that often occurs.

Please indicate if you have ever experienced any emotional/mental stress from the following categories:

Childhood trauma, illness, family stress, lifestyle change, parental divorce, work or school, relationships, financial, abuse (physical or emotional), loss of loved one, other stress? ☐ Yes, a few ☐ Yes, many ☐ No

Do you practice mediation, prayer or other stress reducing activity on a regular basis? ☐ Yes ☐ No

Sleep quality: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

FAMILY HISTORY

Please note any health problems that are present in:

MOTHERS FAMILY:	☐ Heart disease	☐ High BP	☐ Cancer	☐ Stroke	☐ Diabetes	☐ Anxiety/Depression
FATHERS FAMILY:	☐ Heart disease	☐ High BP	☐ Cancer	☐ Stroke	☐ Diabetes	☐ Anxiety/Depression
SIBLINGS:	☐ Heart disease	☐ High BP	☐ Cancer	☐ Stroke	☐ Diabetes	☐ Anxiety/Depression

List any other diseases that "run in your family": _____

Doctor's use only: _____

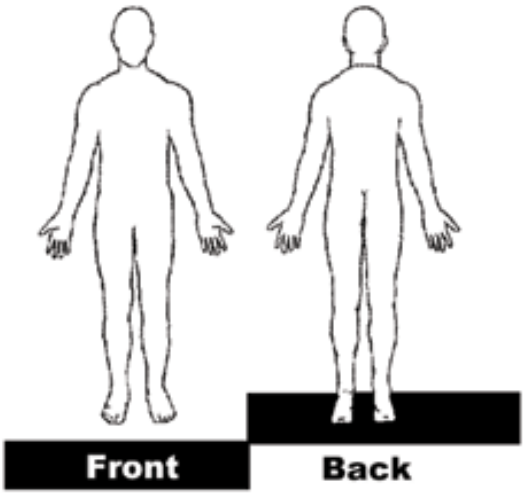
_____

CURRENT HEALTH/PRIMARY COMPLIANT

What is your primary health challenge? _____

Began: _____ Previously occurred: _____

On the diagram to the right please indicate any specific area(s) of health concern. Please circle area of chief compliant or health challenge.



HEALTH AND WELLNESS GOALS

Today we are here to discover your goals and priorities as it relates to your health and wellness. Your answers will help us determine how we can best help you.

Are you healthier today than you were 5 years ago? ☐ Yes ☐ No

If "yes", what did you do to improve your health? _____

If "no", why do you think your health is declining? _____

Will you be healthier 5 years from now than you are today? ☐ Yes ☐ No

If so, what are you planning on doing to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

What would you like your health to be 5 years from now? _____

Check the box next to any area of health and wellness that is important to you:

- ☐ More energy
- ☐ Better concentration
- ☐ Improve digestion
- ☐ Easier/deeper breathing
- ☐ Deeper relaxation
- ☐ More balanced/improved posture
- ☐ Better sleep
- ☐ Enhanced emotional well-being
- ☐ Improved strength and endurance
- ☐ Better sports reaction time, reflexes
- ☐ Other: _____
- ☐ Freedom from pain
- ☐ Reduce/eliminate medication use
- ☐ Greater resistance to disease
- ☐ Overall health improvement

What are your top 3 health and wellness goals?

1) _____ 2) _____ 3) _____

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage every day activates. For each item below, please "X" on the number which most closely describes your condition right now, and then circle were you would like to be.

X = current condition ○ = desired outcome

1. Pain Intensity

No Pain	Mild Pain	Moderate Pain	Severe Pain	Horrific Pain

2. Sleeping

Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

No Pain, No Restrictions	Mild Pain, No Restrictions	Moderate Pain, Need to go Slowly	Moderate Pain, Need Some Assistance	Severe Pain, Need 100% Help

4. Travel (driving, etc.)

No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain, On Long Trips	Moderate Pain, On Short Trips	Severe Pain, On Short Trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

No Pain	Occasional Pain; 25% of the day	Intermittent Pain; 50% of the day	Frequent Pain; 75% of the day	Constant Pain; 100% of the day

8. Lifting

No Pain with heavy weight	Increased Pain with heavy weight	Increased Pain with moderate weight	Increased Pain with light weight	Increased Pain, with any weight

9. Walking

No Pain at any distance	Increased Pain after 1 mile	Increased Pain after ½ mile	Increased Pain after ¼ mile	Increased Pain with all walking

10. Standing

No Pain after several hours	Increased Pain after several hours	Increased Pain after 1 hour	Increased Pain after 30 minutes	Increased Pain with any standing

11. Sitting

No Pain after several hours	Increased Pain after several hours	Increased Pain after 1 hour	Increased Pain after 30 minutes	Increased Pain with any sitting

REVIEW OF SYSTEMS

NERVOUS SYSTEM

☐ I DENY all systems listed below in Nervous System

Past Problem	Current Problem		Past Problem	Current Problem		Past Problem	Current Problem	
☐	☐	Headache/Migraine	☐	☐	Dizziness/Vertigo	☐	☐	Fainting
☐	☐	Paralysis/Weakness	☐	☐	Numb/Tingling	☐	☐	Seizures
☐	☐	Insomnia	☐	☐	Concussion	☐	☐	Fever
☐	☐	Epilepsy	☐	☐	Anxiety/Depression	☐	☐	Multiple Sclerosis

MUSCLES & JOINTS

☐ I DENY all systems listed below in Muscle & Joints

Past	Current		Past	Current		Past	Current	
☐	☐	Back problems	☐	☐	Shoulder problems	☐	☐	Hip problems
☐	☐	Neck pain/stiff	☐	☐	Elbow problems	☐	☐	Knee problems
☐	☐	Painful/stiff Joints	☐	☐	Wrist problem	☐	☐	Ankle/Foot problem
☐	☐	Osteoarthritis	☐	☐	TMJ problems	☐	☐	Spine fracture
☐	☐	Rheumatoid Arthritis	☐	☐	Scoliosis	☐	☐	Hernia

RESPIRATORY

☐ I DENY all systems listed below in Respiratory

Past	Current		Past	Current		Past	Current	
☐	☐	Asthma	☐	☐	Wheezing	☐	☐	Chronic Cough
☐	☐	Shortness of Breath	☐	☐	Emphysema	☐	☐	Cough with Blood
☐	☐	Pleurisy	☐	☐	Pneumonia	☐	☐	Tuberculosis

EENT, SKIN, ALLERGIES

☐ I DENY all systems listed below in EENT, Skin, Allergies

Past	Current		Past	Current		Past	Current	
☐	☐	Glasses or Contacts	☐	☐	Loss of hearing	☐	☐	Sinus problems
☐	☐	Speech difficulty	☐	☐	Ear pain/ringing	☐	☐	Frequent colds
☐	☐	Sore throat	☐	☐	Ear infection	☐	☐	Eczema
☐	☐	Hoarseness	☐	☐	Seasonal allergies	☐	☐	Hives/rash
☐	☐	Swallowing difficulty	☐	☐	Medication allergy	☐	☐	New skin growth/mole
☐	☐	Tonsillitis	☐	☐	Food allergy			

G-I/ENDOCRINE

☐ I DENY all systems listed below in G-I/Endocrine

Past	Current		Past	Current		Past	Current	
☐	☐	Acid Reflux	☐	☐	Frequent diarrhea	☐	☐	Gall Bladder trouble
☐	☐	Ulcer	☐	☐	Frequent Constipation	☐	☐	Liver trouble
☐	☐	Excessive thirst	☐	☐	Frequent Nausea/Vomit	☐	☐	Appendicitis
☐	☐	Diabetes	☐	☐	Black/bloody stool	☐	☐	Hepatitis
☐	☐	Poor Digestion	☐	☐	Hemorrhoids			

CARDIO-VASCULAR

☐ I DENY all systems listed below in Cardio Vascular

Past	Current		Past	Current		Past	Current	
☐	☐	Chest pain	☐	☐	High Blood Pressure	☐	☐	Poor Circulation
☐	☐	Easily Bruised	☐	☐	Heart problems	☐	☐	Rapid/Racing Heart
☐	☐	Stroke	☐	☐	Irregular Heart Beat/Murmur	☐	☐	Swollen ankles
☐	☐	Varicose Veins	☐	☐	Thyroid problems	☐	☐	Anemia

GENITO-URINARY

☐ I DENY all systems listed below in Genito-Urinary

Past	Current		Past	Current		Past	Current	
☐	☐	Blood in Urine	☐	☐	Frequent Urination	☐	☐	Bladder Infection
☐	☐	Kidney Infection	☐	☐	Painful Urination	☐	☐	Prostate trouble

GENERAL

☐ I DENY all systems listed below in General

Past	Current		Past	Current		Past	Current	
☐	☐	Chills/Sweats	☐	☐	Weight Loss	☐	☐	Cancer
☐	☐	Fatigue	☐	☐	Weight Gain			

☐ Other Not Listed: _____

Doctor's Use Only

FEMALES ONLY

☐ I DENY all systems listed below in Females Only

Past	Current		Past	Current		Past	Current	
☐	☐	Backache with Period	☐	☐	Painful Periods	☐	☐	Last Period: _____
☐	☐	Miscarriage	☐	☐	Abnormal Discharge	☐	☐	Pregnant: yes no EDD _____
☐	☐	Infertility	☐	☐	Hot Flashes	☐	☐	Number of Pregnancies: _____
☐	☐	Irregular Cycle	☐	☐	Menopausal Symptoms	☐	☐	Number of Live Births: _____