POLOCHICK CHIROPRACTIC WELLNESS CENTER
2090 ACUSHNET AVENUE, NEW BEDFORD, MA 02745
Phone: 508-995-3428 / Fax: 508-998-7262

APPLICATION FOR CARE

Whom may we thank for referring you to this office: _____?

Today's Date: _____ PT ID #: _____

PATIENT DEMOGRAPHICS

Name _____ Birth Date _____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Phone _____ Cell _____

Single/Married/Other Do you have Health Insurance? Yes/No SS# _____

Employer _____ Retired/Occupation _____

Spouse's Name _____ Spouse's Employer _____

Number of Children & Ages _____

Emergency Contact _____ Phone _____ Relationship _____

HISTORY OF COMPLAINT

Reason for visit: *Wellness / Health Concerns / Pain / Injury* (Please explain injury) _____

Please list current conditions and on a scale of *1* to *10* (0=no pain, 10=worst pain) please rate your pain for the complaint

1. _____ Pain: *0 – 1 - 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10*
2. _____ Pain: *0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10*
3. _____ Pain: *0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10*
4. _____ Pain: *0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10*

When did the problem(s) begin? _____ When is problem at its worst? AM / mid-day / PM / Sleeping
How long does it last? Constant / on-off during day / comes and goes throughout the week

Condition(s) ever been treated by anyone in the past? No / Yes, when _____ by whom _____
How long were you under care? _____ Results _____

Name of Previous Chiropractor _____ N/A

What relieves your symptoms? Ice / Heat / Rest / Motrin / Muscle Relaxers / Physical Therapy / Other _____

What makes symptoms worse?_____

Specific Activity Scoring: on a scale of *0 -1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10*
(0=unable to perform activity - 10 (fully able to perform activity)
Please list any restricted activities and score

List Activities: (ex; shopping, walking, working, exercising, sex, housework, gardening, etc.)

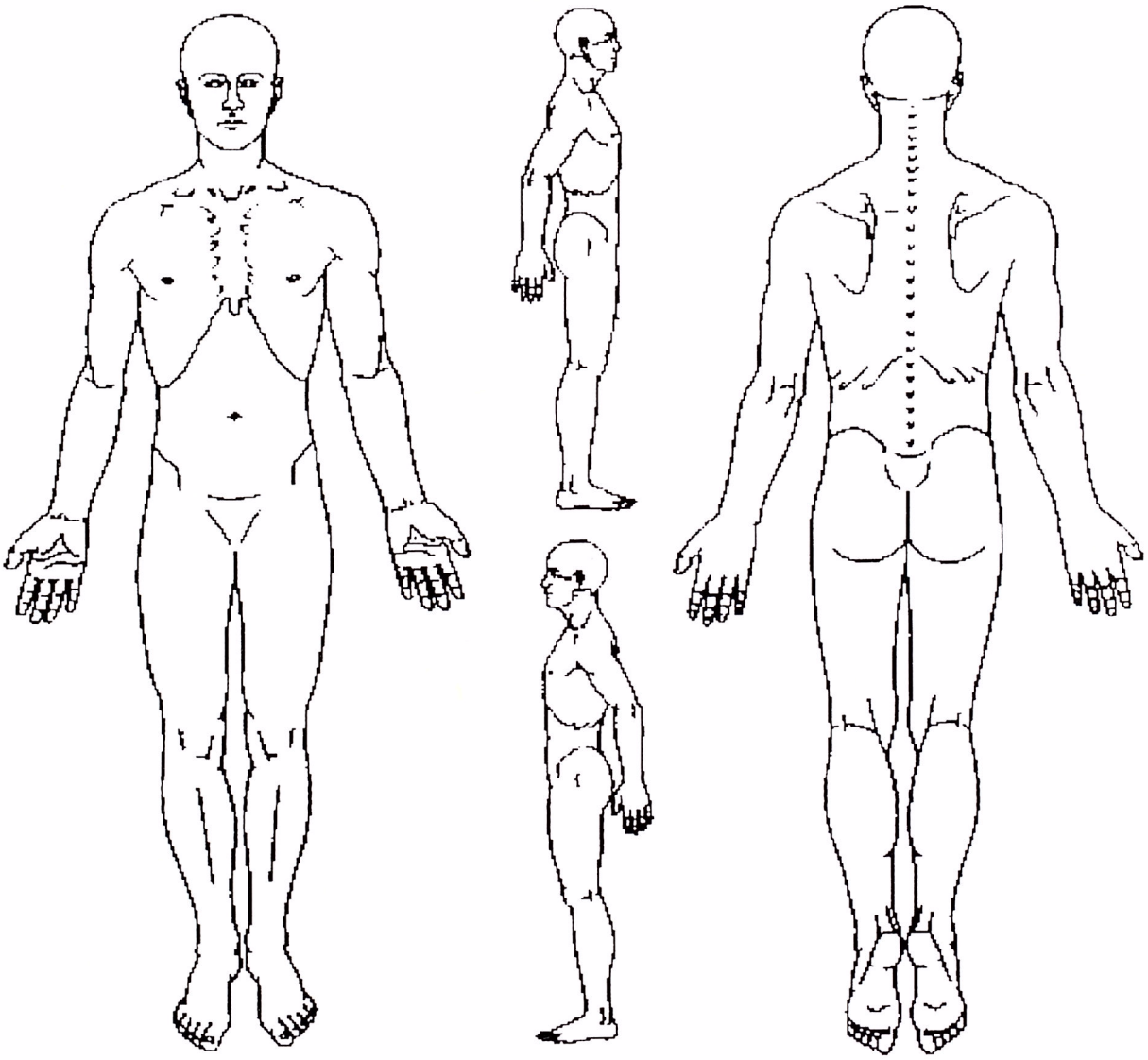
1. _____ Score _____
2. _____ Score _____
3. _____ Score _____
Additional _____ Score _____

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

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Application for Care

PAST HISTORY

Please identify any other injury(s) to your spine, minor or major that the doctor should know about:

_____

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

_____

Have your ever been diagnosed with any of the following conditions;
Broken Bone / Dislocations / Fracture / Disability / Tumors / Cancer / Rheumatoid Arthritis / Osteo Arthritis / Diabetes
Heart Attack / Cerebral Vascular / Other _____

Please identify all past and current conditions you feel may be contributing to your present problem

Condition	How Long Ago	Type of Care Received	By Whom
Injuries	_____	_____	_____
Surgeries	_____	_____	_____
Childhood Diseases	_____	_____	_____
Adult Diseases	_____	_____	_____

SOCIAL HISTORY

1. Smoking: Cigars / Pipe / Cigarettes — How Often? Daily / Weekends / Occasionally / Never
2. Alcoholic Beverage — How Often? Daily / Weekends / Occasionally / Never
3. Recreational Drug use — How Often? Daily / Weekends / Occasionally / Never
4. Hobbies / Recreational Activities / Exercise Regime — How Often? Daily / Weekends / Occasionally / Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s) No / Yes
   grandparent / mother / father / sibling / children – Have they ever been treated for their condition No / Yes
2. Any other hereditary conditions the doctor should be aware of? No / Yes _____

_____

I hereby authorize payment to be made directly to Polochick Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Polochick Chiropractic for any and all services I receive at this office.

_____ _____

Patient/Guardian's Signature *Date*

_____ _____

Doctor's Signature *Date Reviewed*

Patient Name: _____ Pt ID# _____ Date _____