WESTCHASE
CHIROPRACTIC AND WELLNESS

Reducing Neurological, Chemical, & Emotional Interference.

PATIENT APPLICATION FORM

WELCOME TO OUR OFFICE. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to helping you achieve maximum health!

Patient Signature _____ Date: _____

Westchase Chiropractic
10981 Countryway Blvd
Tampa, FL 33626

Name: _____ Date: _____

MIND

Reason for seeking Care Get out of pain Get healthy Wellness Evaluation

What are your life goals and where do you see yourself in the next 5 to 10 years?

1. _____

2. _____

3. _____

How long do you sit per day? _____ hrs

NERVE SUPPLY

When was the last time you had spinal X-Ray? Date: _____ N/A

When was your last Chiropractic Adjustment? Date: _____ N/A

Was it: □ System care □ Corrective care

NUTRITION

Are you looking to: (circle all the apply)

Decrease medication Rebalance Hormones Detox Weight Loss Wellness

EXERCISE

How many times per week do you exercise? _____ /week

What type of exercise do you perform? Cardio Weights Metabolic Conditioning

Other: _____

ROMOVING TOXINS

How many cups of water do you drink each day? _____ /day

On average how often do you have bowel movements? _____ /day (or) _____ /week

APPLICATION FOR CARE

Date: _____

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City, State, Zip: _____ Gender M F

Email Address: _____

Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Occupation: _____ # of Children: _____ Spouse's Name: _____

Name & Number of Emergency Contact: _____

Relationship:_____ Do you have insurance? ☐ Yes ☐ No

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

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of **1** to **10** (zero = no pain; 10 = worst pain)

1. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

2. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

3. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

4. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? _____

When is the problem at its worst? ☐ Morning ☐ Mid-day ☐ Evening

How long does it last? ☐ constant throughout day ☐ I experience it on and off during the day

☐ it comes and goes throughout the week

How did the injury happen? _____

Has the condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

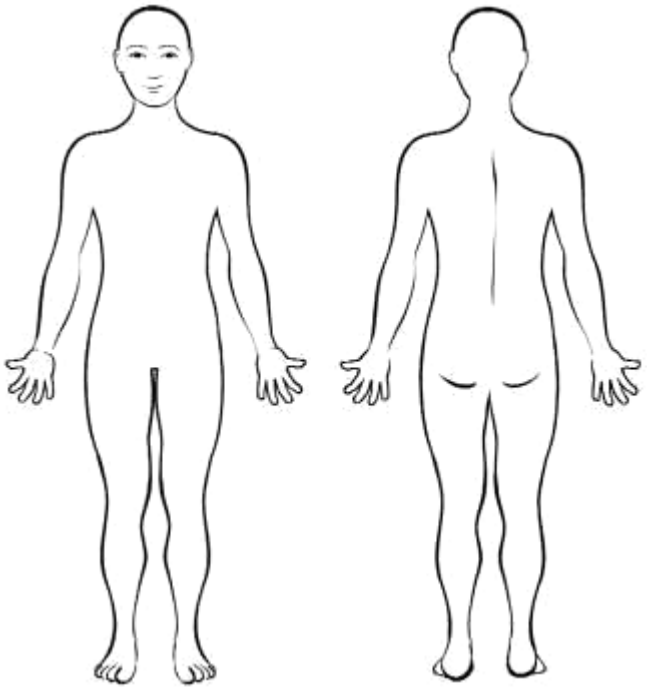
If yes, when: _____ and by whom? _____

How long were you under care: _____

What were the results: _____

PLEASE MARK
the areas on the diagram with the following letters
to describe your symptoms:

R = **R**adiating
B = **B**urning
D = **D**ull
T = **T**ingling
A = **A**ching
N = **N**umbness
S = **S**harp/**S**tabbing



What relieves your symptoms? _____

_____

What makes them feel worse? _____

_____

Is your problem the result of any type of accident? Yes No
Explain: _____

SOCIAL HISTORY

1. Smoking: □ cigars □ pipe □ cigarettes □ vape □ Daily □ Weekends □ Occasionally □ Never
2. Alcoholic beverage consumption: □ Daily □ Weekends □ Occasionally □ Never
3. **Females: Is there any chance that you are pregnant?** □ Yes □ No
4. **If no, when was your last cycle?** _____

MEDICATION / VITAMIN HISTORY

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently taking: _____

_____

_____

_____

_____

_____

_____

I hereby authorize payment to be made directly to Westchase 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 affecting 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 Westchase Chiropractic for any and all services I receive at this office that are not covered under a healthcare plan.

_____ _____
Signature of Patient or Authorized Person Date

_____ _____
Signature of Doctor Date

ACTIVITIES OF DAILY LIVING

Name: _____ Date: _____

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life.

Reading/Concentration	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying/Lifting (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bending	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Stand to Sit Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Playing Sports	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Running	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Working	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other:	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
:	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Please mark the listed items below as: **P (Past)** **C (Currently)** **N (Never)**

____ Headache
____ Neck Pain
____ Jaw Pain, TMJ
____ Shoulder Pain
____ Upper Back Pain
____ Mid Back Pain
____ Low Back Pain
____ Hip Pain
____ Back Curvature
____ Scoliosis
____ Numb/Tingling Arms, Hands, and Fingers
____ Numb/Tingling Legs, Feet, and Toes
____ Knee Problems
____ Foot Problems
____ Swollen/Painful Joints
____ Pregnant (Now)
____ Frequent Colds/Flu
____ High Cholesterol
____ Other

____ Pain w/ Cough/Sneeze
____ Allergies
____ Sinus/Drainage Problem
____ Convulsions/Epilepsy
____ Tremors
____ Dizziness
____ Loss of Balance
____ Fainting
____ Double Vision
____ Blurred Vision
____ Ringing in Ears
____ Hearing Loss
____ Asthma
____ Difficulty Breathing
____ Lung Problems
____ Heart Problem
____ Heart Attack
____ Heartburn
____ Chest Pain
____ High Blood Pressure
____ Low Blood Pressure

____ Digestive Problems
____ Colon Trouble
____ Diarrhea/Constipation
____ Kidney Trouble
____ Gall Bladder Trouble
____ Liver Trouble
____ Prostate Problems
____ Sexual Dysfunction
____ Menstrual Problems
____ PMS
____ Menopausal Problems
____ Depression
____ Irritable
____ Bed Wetting
____ Skin Problems
____ Learning Disability
____ ADD/ADHD
____ Eating Disorder
____ Trouble Sleeping
____ Ulcers

Further Explanation

Patient Signature

Date