CHAMPION
WELLNESS CENTERS

CHAMPIONWELLNESS.COM

APPLICATION FOR CARE

Date: _____

Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

City, State, Zip: _____ **Cell Phone:** _____

E-mail 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

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? ☐ early AM ☐ mid-morning ☐ mid-day ☐ early evening ☐ late 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? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

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:** _____

Name of previous chiropractor: _____ N/A

PLEASE MARK the areas on the diagram with the following letter s to descr ibe your symptoms:

R = Radiating A = Aching
B = Burning N = Numbness
D = Dull S = Sharp/Stabbing
T = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Please list any restricted activities, your current activity level, and your usual activity level:

RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
ex: walking	*ex: walk half mile 2x/week*	*ex: walk one mile 4x/week*

Identify any other injuries to your spine, minor or major, that the doctor should know about: _____

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

Women: Is there any chance that you are pregnant? ☐ Yes ☐ No

Past History:

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No

If yes, how many times? _____ **When was the last episode?** _____

How did the injury happen? _____

Have you tried any other forms of treatment: ☐ Yes ☐ No

If yes, please state what type of treatment: _____ **, and who provided it:** _____

How did the injury happen? _____

How long ago? _____ **What were the results:** ☐ favorable ☐ unfavorable -- please explain: _____

_____

Please identify any and all types of jobs, activities, or events you have experienced in the past that have imposed any physical stress on you or your body: _____

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P = in the Past **C =** Currently **N =** Never have had:

_____ broken bone	_____ disability	_____ cancer	_____ rheumatoid arthritis
_____ osteoarthritis	_____ diabetes	_____ cerebrovascular	_____ heart attack
_____ dislocations	_____ tumors	_____ thyroid disorder	_____ other: _____

Please identify ALL PAST and any 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 ☐ daily ☐ weekends ☐ occasionally ☐ never

2. Alcoholic beverage consumption: ☐ daily ☐ weekends ☐ occasionally ☐ never

3. Recreational drug use: ☐ daily ☐ weekends ☐ occasionally ☐ never

4. Hobbies/recreational activities/exercise/sports: _____

Family History:

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sibling(s) ☐ son(s) ☐ daughter(s)

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No

Quadruple Visual Analogue Scale:

Instructions: Please circle the number that best descr ibes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the source for each complaint (see example below).

Example:

Headache *Neck* *Low Back*

No pain **0** **1** (**2**) **3** **4** (**5**) **6** **7** (**8**) **9** **10** Worst Possible Pain

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1. What is your pain level *right now?*

No pain **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** Worst Possible Pain ☐

2. What is your *typical or average* level of pain?

No pain **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** Worst Possible Pain ☐

3. What is your pain level *at its best* (how close to "0" does your pain get at its best)?

No pain **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** Worst Possible Pain ☐

4. What is your pain level *at its worst* (how close to "10" does your pain get at its worst)?

No pain **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** Worst Possible Pain ☐

Other Comments: _____

_____

_____

OATS Score: _____ **%**

Activities of daily living:

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

Reading/Concentrating	☐ 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
Taking out Garbage	☐ 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 (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
Yard Work	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ 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
Dishes	☐ N/A	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ 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

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
____ numb/tingling hands/fingers
____ numb/tingling legs
____ numb/tingling feet/toes
____ knee problems
____ foot problems
____ swollen/painful joints
____ frequent colds/flu
____ 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 problems
____ heartburn
____ chest pain
____ high blood pressure
____ low blood pressure
____ ulcers
____ digestive problems
____ colon trouble
____ diarrhea/constipation
____ kidney trouble
____ gallbladder trouble
____ liver trouble
____ prostate problems
____ impotence
____ menstrual problems
____ PMS
____ menopausal problems
____ depression
____ irritable
____ bed wetting
____ skin problems
____ mood changes
____ learning disability
____ ADD/ADHD
____ eating disorder
____ trouble sleeping
____ Hepatitis (A, B, C)
____ other:

I hereby authorize payment to be made directly to Champion Wellness Centers 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 Risoldi Family 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

Notes: _____