# APPLICATION FOR CARE AT STUCKEY CHIROPRACTIC

**Today's Date:** _____ **Acct. #:** _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female
Name you wish to be called in our office: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____
Mobile Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Occupation: _____
Names and Ages of your children: _____
Name & Number of Emergency Contact: _____ Relationship: _____

## HISTORY of COMPLAINT(s)

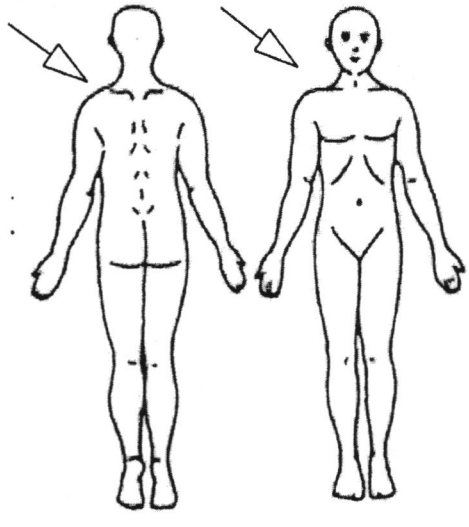
Primary Problem: _____

**When did problem begin?** _____
**What relieves your symptom?** Rest Ice Heat Movement Stretching Other: _____
**What makes your symptom worse?** Sitting Standing Walking Sleeping Overuse Other _____
**Frequency:** Off & On / Constant **Does the pain radiate?** No / Yes **Where?** _____
**How long does this problem last?** _____ **# of prior episodes?** _____
**Type of Pain:** Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
**(Circle the number)**: 0 1 2 3 4 5 6 7 8 9 10

Secondary Problem: _____

**When did problem begin?** _____
**What relieves your symptom?** Rest Ice Heat Movement Stretching Other: _____
**What makes your symptom worse?** Sitting Standing Walking Sleeping Overuse Other _____
**Frequency:** Off & On / Constant **Does the pain radiate?** No / Yes **Where?** _____
**How long does this problem last?** _____ **# of prior episodes?** _____
**Type of Pain:** Sharp Stabbing Dull Achy Burning Stiff Sore
On a scale of **0 to 10** with **10** being the worst and **0** being pain free, rate how you feel today:
**(Circle the number)**: 0 1 2 3 4 5 6 7 8 9 10

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms: **R = Radiating B = Burning D = Dull**
**A = Aching N = Numbness S = Sharp/ Stabbing T= Tingling**



Do your symptoms cause you to feel worse in the ☐AM ☐PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes
**If yes, Who** provided: _____
**How long ago?** _____ What **type** of treatment did you receive? _____
**What** were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain: _____
List any **medications** taken to treat these conditions: _____
Did they help? ☐ No ☐ Yes If you still take them how often? _____
Have you ever been under chiropractic care? ☐ No ☐ Yes
**If yes,** how long ago: _____ Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes
**If yes,** How long ago? _____ Please explain what type of accident: _____