



3520 Snouffer Rd, Suite 202 Columbus, OH 43235 (567)-230-4156

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

CARE APPLICATION FOR APOLLO FAMILY CHIROPRACTIC

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Do you have Insurance: Yes No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Are you or your spouse current or former military, police or fire? Yes No

PATIENT'S NAME: _____ HR#: _____ Date: _____

THE CASE HISTORY

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Conditioned Based Care, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins Corrective Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

LOSS of WELLNESS (BIRTH-AGE 5)

At birth, when your nerve system is first damaged, your wellness begins to decrease and the journey to ill health starts.

Yes	No		Patient Comment (if answer is yes)	Chiropractor's Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. Pregnancy		
		<i>Did your mother:</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Smoke or drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have a proper diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise through her pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any falls and injuries during pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any physical and/or mental abuse?	_____	_____
		2. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
		3. Growth and Development		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you roll out of bed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you a headbanger or rocker?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breastfed?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____	_____

PATIENT'S NAME: _____ HR#: _____ Date: _____

- Pulled ear/chin? _____
- Chair pulled out when sat down? _____
- Did you fall down stairs? _____
- Were you yanked by your arm? _____
- Did you have other traumas? What? When? _____

LOSS of WHOLE BODY HEALTH (AGE 5-PRESENT)

As layers of damage increased, you probably began to experience symptoms and random bouts of sickness.

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: **Primary:** _____

Secondary: _____ **Third:** _____ **Fourth:** _____

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is: ○ - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: ○ - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: ○ - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: ○ - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant OR I experience it on and off during the day OR It comes and goes throughout the week

How did the injury happen? _____

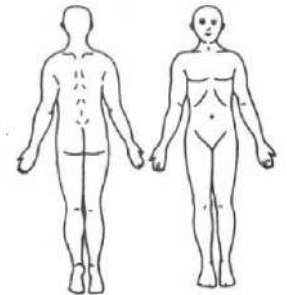
Condition(s) ever been treated by anyone in the past? Yes No **If yes, when:** _____ **by whom?** _____

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 **letters** to describe your symptoms:

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



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	<input type="checkbox"/> _____	<input type="checkbox"/> _____
_____:	<input type="checkbox"/> _____	<input type="checkbox"/> _____
_____:	<input type="checkbox"/> _____	<input type="checkbox"/> _____
_____:	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Is your problem the result of ANY type of accident?

Yes, No

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

PATIENT'S NAME: _____ HR#: _____ Date: _____

PAST HISTORY

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:

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have or **N** for **Never** have had:

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:			
WHOM	HOW LONG AGO	TYPE OF CARE RECEIVED	BY
	7		
INJURIES	7		
SURGERIES	7		
CHILDHOOD DISEASES	7		
ADULT DISEASES			

FAMILY HISTORY

- Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
 Have they ever been treated for their condition? No Yes I don't know
- Any** other hereditary conditions the doctor should be aware of? No Yes: _____

SOCIAL HISTORY

- Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- Recreational Drug use:** Daily Weekends Occasionally Never
- Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect? (See ADL form)

I hereby authorize payment to be made directly to Steiner Family 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 Steiner Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ Date: _____