APPLICATION FOR CARE AT ROXBURY SPINE AND WELLNESS CLINIC

OFFICE USE ONLY
ACCEPTED FOR CARE
BY DOCTOR.
Initial ________ Date_______

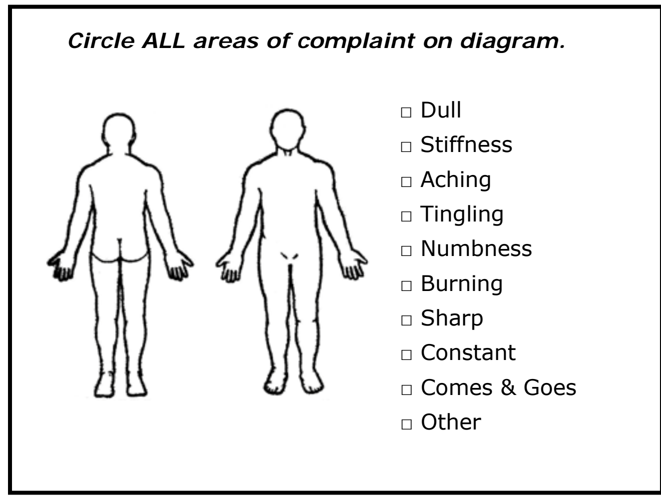
FIRST NAME ______________________________ LAST NAME ______________________________ MIDDLE ______
ADDRESS ______________________________ SS# ____________________ BIRTHDATE _______________AGE_______
CITY ______________________ STATE _____ ZIP __________ DL# __________________ E-MAIL ______________________
OCCUPATION ______________________________ (CIRCLE ONE) **Single** **Married** **Divorced** **Widowed**
EMPLOYER ______________________________ SPOUSE ____________________ OCCUPATION____________________
CELL# ______________________________ SPOUSE'S EMPLOYER ______________________________
HOME# ______________________ WORK ____________________ KIDS NAMES & AGES 1.__________________ 2.__________________
INSURANCE CO. ______________________________ 3.__________________ 4.__________________
POLICY # ________________ CONTACT______________________ HOW DID YOU HEAR ABOUT US? ______________________________

IN CASE OF EMERGENCY:

NAME OF LOCAL FRIEND OR RELATIVE:
____
RELATIONSHIP TO PATIENT: ______________________________
CELL PHONE NO: ________________ WORK PHONE: ______________

What is your **1st** complaint? ______________________________
How intense is it on a scale of 1-10? (1-least, 10-worst)__________
How often do you feel it? □ 25% □ 50% □ 75% □ 100%
When did this condition first develop?__________ First time? **Yes No**
Is your problem the result of ANY accident? **Yes** **No**
If yes identify type: □ Auto □ Work □ Home □ Other (please explain)
____
What makes it worse?______________________________
What have you done to help yourself?______________________________
Has the problem been getting: □ Worse □ Better □ Staying the same

What is your **2nd** complaint? ______________________________
How intense is it on a scale of 1-10? (1-least, 10-worst)____________
How often do you feel it? □ 25% □ 50% □ 75% □ 100%
What is your **3rd** complaint? ______________________________
How intense is it on a scale of 1-10? (1-least, 10-worst)____________
How often do you feel it? □ 25% □ 50% □ 75% □ 100%
What is your **4th** complaint? ______________________________
How intense is it on a scale of 1-10? (1-least, 10-worst)____________
How often do you feel it? □ 25% □ 50% □ 75% □ 100%



Please mark if you have you EVER had any of the following health issues:

□ Neck Problems	□ Sore Muscles	□Allergies
□ Shoulder Problems	□ Walking Problems	□ Hay Fever
□ Arm Problems	□ Broken Bones	□ Asthma
□ Numbness in Hands	□ Muscle Cramps	□ Eczema
□ Pain Between Shoulders	□ Weak Muscles	□ Shingles
□ Low Back Problems	□ Dizziness	□ Poor Digestion
□ Leg Problems	□ Fainting	□ Ulcers
□ Numbness in Legs	□ Forgetfulness	□ Diarrhea
□ Loss of Feeling	□ Depression	□ Constipation
□ Stiff Joints	□ Vision Problems	□ Kidney Infection
□ Painful Joints	□ Ear Pain/Noises	□ Menstrual Cramps
□ Restricts Activities	□ Ear Infections	□ Diabetes
□ Restricts Exercise	□ Hearing Loss	□ Blood Pressure Hi/Lo
□ Headaches	□ Tiredness/Fatigue	□ Frequent Colds

This is a □ new / □ old condition. I have □ / □ haven't had care for it before.
If previous care, what was done? ______________________________
____
Name of Doctors: ______________________________
____
Have you ever had surgery or been hospitalized? □ Y / N □
List surgeries: ______________________________
____

Have you EVER had chiropractic care before? □ Y / N □
Name of Doctors: ______________________________
____
Was it a good experience? □ Y / N □
Last time you had spinal x-rays or other x-rays: ______________
Primary/Family Doctor: ______________________________
Phone #: ______________________________

List **All** medications currently taking: ______________________________