FARE CHIROPRACTIC APPLICATION FOR TREATMENT

General Patient Information

LAST NAME _____ FIRST _____ MI _____
DATE OF BIRTH _____/_____/_____ AGE _____ SEX MALE / FEMALE RACE:_____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE#( )_____CELL#( )_____WORK#( )_____
WHICH OF THE ABOVE PHONE NUMBERS WOULD YOU LIKE TO RECEIVE YOUR REMINDER CALLS?

CHECK ONE: ____HOME ____CELL ____WORK

IF YOU ARE UNABLE TO ANSWER YOUR PHONE, MAY WE HAVE PERMISSION TO LEAVE YOU A MESSAGE? ____YES ____NO
MARTIAL STATUS: M S D W

IN CASE OF EMERGENCY CONTACT _____ PHONE # ( )_____
RELATIONSHIP:_____
HOW DID YOU HEAR ABOUT OUR OFFICE?_____

WHO IS YOUR FAMILY DOCTOR? _____
MAY WE HAVE PERMISSION TO CONSULT WITH THEM ABOUT YOUR CARE? ____YES ____NO

****

History of Complaint(s)

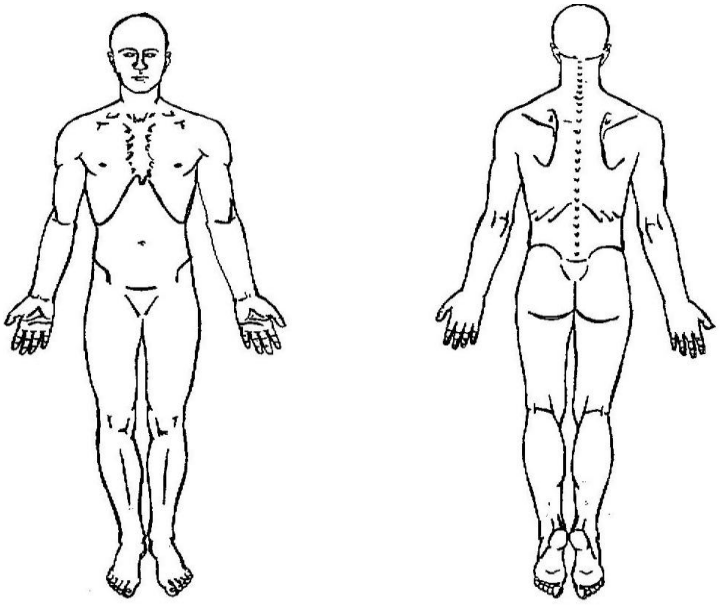
PLEASE CHECK ALL ANSWERS AND FILL IN BLANKS WHERE APPROPRIATE.

Describe the problem(s) which brings you to this office today:
1._____2._____
3._____4._____
5._____6._____

Pain Drawing

Please Mark all of the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Pain = P
Stiffness = S
Burning = B
Numbness = N
Tingling = T



FARE CHIROPRACTIC- Dr. Todd E. Fare-537-D Balto.-Annap. Blvd. Severna Park, Md. 21146

PATIENT NAME_____ DATE____/____/____

Problem/Complaint 1:_____

Please describe the character of your current pain (You may check one or more answers):
__ Sharp/stabbing __ Aching __ Dull/diffuse __ Constricting __ Weakness __Throbbing/gnawing
__Numbness __ Shooting __Burning __Tingling __Other_____
How often are the complaints present? __ Constant (76-100%) __Frequent (51-75%) __Occasional (26-50%)
__ Intermittent (25% or less)
How bad is your pain or complaint? (Please circle one) **0** 1 2 3 4 5 6 7 8 9 **10**
B=Best W=Worst A=Average **NO PAIN** ← → **UNBEARABLE PAIN**
Has your problem been: __ Increasing __ Decreasing __ Not changing
When did your problem begin? (Specific date if possible) _____
Did your problem begin: __ Immediately after a specific incident (Date of Incident:____/____/____)
Description of Incident:_____
__Multiple incidents __Gradually __Don't Know
Have you had the same or similar conditions in the past? __ Yes __No How many episodes? _____
What makes your problem **BETTER**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____
What makes your problem **WORSE**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____
What activity/activities are you **unable** to perform without pain ? (please circle) housework / yardwork /
personal grooming / driving / walking / sitting / standing / sleeping / exercising / bending / lifting
Have you already been treated for this problem by another healthcare provider? __Yes __ No
If yes: __ MD __ DO __ Chiropractor/DC __ Physical therapist/PT __ Emergency room/ER
__ Other (Please specify) _____
Dates, types and results of treatments. _____
_____
_____
_____
Have you had x-rays, an MRI or any other special tests? __ Yes __ No Please list:_____
_____
_____
_____

Problem/Complaint 2:_____

Please describe the character of your current pain (You may check one or more answers):
__ Sharp/stabbing __ Aching __ Dull/diffuse __ Constricting __ Weakness __Throbbing/gnawing
__Numbness __ Shooting __Burning __Tingling __Other_____
How often are the complaints present? __ Constant (76-100%) __Frequent (51-75%) __Occasional (26-50%)
__ Intermittent (25% or less)
How bad is your pain or complaint? (Please circle one) **0** 1 2 3 4 5 6 7 8 9 **10**
B=Best W=Worst A=Average **NO PAIN** ← → **UNBEARABLE PAIN**
Has your problem been: __ Increasing __ Decreasing __ Not changing
When did your problem begin? (Specific date if possible) _____
Did your problem begin: __ Immediately after a specific incident (Date of Incident:____/____/____)
Description of Incident:_____
__Multiple incidents __Gradually __Don't Know
Have you had the same or similar conditions in the past? __ Yes __No How many episodes? _____
What makes your problem **BETTER**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____
What makes your problem **WORSE**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____

PATIENT NAME_____ DATE____/____/____

Problem/Complaint 2(cont'd):

What activity/activities are you **unable** to perform without pain ? (please circle) housework / yardwork / personal grooming / driving / walking / sitting / standing / sleeping / exercising / bending / lifting

Have you already been treated for this problem by another healthcare provider? __Yes __ No

If yes: __ MD __ DO __ Chiropractor/DC __ Physical therapist/PT __ Emergency room/ER __ Other (Please specify) _____

Dates, types and results of treatments. _____

_____

_____

_____

Have you had x-rays, an MRI or any other special tests? __ Yes __ No Please list:_____

_____

_____

_____

Problem/Complaint 3:_____

Please describe the character of your current pain (You may check one or more answers):

__ Sharp/stabbing __ Aching __ Dull/diffuse __ Constricting __ Weakness __Throbbing/gnawing

__Numbness __ Shooting __Burning __Tingling __Other_____

How often are the complaints present? __ Constant (76-100%) __Frequent (51-75%) __Occasional (26-50%) __ Intermittent (25% or less)

How bad is your pain or complaint? (Please circle one) **0** 1 2 3 4 5 6 7 8 9 **10**

B=Best W=Worst A=Average **NO PAIN** ← → **UNBEARABLE PAIN**

Has your problem been: __ Increasing __ Decreasing __ Not changing

When did your problem begin? (Specific date if possible) _____

Did your problem begin: __ Immediately after a specific incident (Date of Incident:____/____/____)

Description of Incident:_____

__Multiple incidents __Gradually __Don't Know

Have you had the same or similar conditions in the past? __ Yes __No How many episodes? _____

What makes your problem **BETTER**? __ Lying down __ Walking __ Standing __ Sitting __ Movement __ Inactivity __ Nothing __ Other (Please specify)_____

What makes your problem **WORSE**? __ Lying down __ Walking __ Standing __ Sitting __ Movement __ Inactivity __ Nothing __ Other (Please specify)_____

What activity/activities are you **unable** to perform without pain ? (please circle) housework / yardwork / personal grooming / driving / walking / sitting / standing / sleeping / exercising / bending / lifting

Have you already been treated for this problem by another healthcare provider? __Yes __ No

If yes: __ MD __ DO __ Chiropractor/DC __ Physical therapist/PT __ Emergency room/ER __ Other (Please specify) _____

Dates, types and results of treatments. _____

_____

_____

_____

Have you had x-rays, an MRI or any other special tests? __ Yes __ No Please list:_____

_____

_____

_____

PATIENT NAME_____ DATE____/____/____

Problem/Complaint 4:_____

Please describe the character of your current pain (You may check one or more answers):
__ Sharp/stabbing __ Aching __ Dull/diffuse __ Constricting __ Weakness __Throbbing/gnawing
__Numbness __ Shooting __Burning __Tingling __Other_____
How often are the complaints present? __ Constant (76-100%) __Frequent (51-75%) __Occasional (26-50%)
__ Intermittent (25% or less)
How bad is your pain or complaint? (Please circle one) **0** 1 2 3 4 5 6 7 8 9 **10**
B=Best W=Worst A=Average **NO PAIN** ← → **UNBEARABLE PAIN**
Has your problem been: __ Increasing __ Decreasing __ Not changing
When did your problem begin? (Specific date if possible) _____
Did your problem begin: __ Immediately after a specific incident (Date of Incident:____/____/____)
Description of Incident:_____
__Multiple incidents __Gradually __Don't Know
Have you had the same or similar conditions in the past? __ Yes __No How many episodes? _____
What makes your problem **BETTER**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____
What makes your problem **WORSE**? __ Lying down __ Walking __ Standing __ Sitting __ Movement
__ Inactivity __ Nothing __ Other (Please specify)_____
What activity/activities are you **unable** to perform without pain ? (please circle) housework / yardwork /
personal grooming / driving / walking / sitting / standing / sleeping / exercising / bending / lifting
Have you already been treated for this problem by another healthcare provider? __Yes __ No
If yes: __ MD __ DO __ Chiropractor/DC __ Physical therapist/PT __ Emergency room/ER
__ Other (Please specify) _____
Dates, types and results of treatments. _____
_____
_____
_____
Have you had x-rays, an MRI or any other special tests? __ Yes __ No Please list:_____
_____
_____
_____

What is your present height? ____feet ____inches What is your present weight? ____ pounds

PATIENT SIGNATURE _____ DATE_____/_____/_____