# INTERMEDIATE APPLICATION FOR CARE AT HANDS ON HEALTH CHIROPRACTIC

Today's Date: _____

## PATIENT DEMOGRAPHICS

Name: _____ Has any of your demographics information changed? O Yes O No

Has your insurance information changed? O Yes O No Has your work information changed? O Yes O No

## HISTORY OF COMPLAINT

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

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** 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: | 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| **Second** complaint is: | 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| **Third** complaint is: | 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |
| **Fourth** complaint is: | 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 |

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

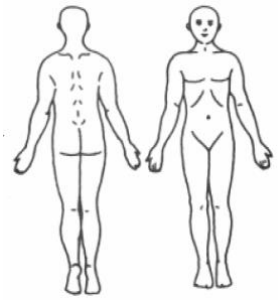
How long does it last? O It is constant **OR** O I experience it on and off during the day **OR** O It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? O No O Yes **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 body diagram with the following **letters** to describe your symptoms:

**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

| LIST RESTRICTED ACTIVITY | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

I hereby authorize payment to be made directly to Hands on Health 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 Hands on Health 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**