Application for Care

Name(Print):____Date:__________
Last First M
Preferred Name for us to address you by? ____________________
Date of Birth:_________________ Age:__________
Gender: _________________
Does this match your gender assigned at birth? **Yes** **No** **Decline to Answer**
Preferred Pronouns (for example, Dr. Pam's are she/her) __________

Address:____ City:_____________________
State:________ Zip:___________
Home Phone:_________________________ Cell :_____________________________
SSN:___________________________________
Email:_______________________________________@_________________________
Do you have any type of Health Insurance? **Yes** **No** If yes, Company:____________________
Are you covered by Medicare? **Yes** **No**

Occupation________________________Employed by_______________________________________

Currently Pregnant? ___________ Estimated Due Date:_____________
# of Pregnancies: _____________ # of Live births: _________

Relationship Status:_________________ Name of Spouse/Partner____________________________

Who may we thank for referring you to our office?_____________________________________
Have you ever had Chiropractic Care? (Circle) **Yes** or **No**
If yes, when was your last visit? ____________________

Health Concerns (please rate in order of severity below)

Concern	Severity (scale of 1-10)	When did this episode start?	Have you had this condition before? When?	Did this start with an injury?	Is it a constant concern?

For which, if any, of these conditions have you seen another doctor?
____

Please list any current conditions you have with the following systems:
Skin (eczema, psoriasis, lupus, hives, etc.)____

Musculoskeletal (osteoporosis, rheumatoid arthritis, etc.): ______________________________

Cardiovascular (hypertension, high cholesterol, clotting disorders, etc.): ___________________

Endocrine (diabetes, hypo/hyperthyroidism, etc.): ______________________________________

Respiratory (COPD, asthma, etc.): ____

Digestive (Irritable bowel, constipation, reflux, etc.): ___________________________________

Urinary (UTI, kidney stones, etc.): ____

Reproductive (PMS, infertility, ED, PCOS, etc.): _______________________________________

Immune (allergies [please list], frequent colds, autoimmune disorders, etc.): ________________

Ear, nose, throat (ear infections, chronic sinus issues, etc.): _____________________________

Nervous (sciatica, multiple sclerosis, Parkinson's Diseases, etc.): _______________________

Sensory and Psychological (ADD/ADHD, anxiety, depression, autism, OCD, etc.): _________

Please circle any condition you have currently or have had previously:
Stroke   Cancer   Heart Disease   Spinal Surgery   Seizures   Fracture   Scoliosis

Please list any current medications, vitamins, and supplements (prescription or over the counter):____
____

Please list any previous surgeries or hospitalizations and approximate date of occurrence:
____
____
____

Have you ever had x-rays taken? If so, please list area x-rayed, where they were taken and approximate date:____
____

When was your last auto accident? ________Have you ever been knocked unconscious? ____

Please list your current health goals below!

Health Goal: (ex. Get rid of migraines)	Date to accomplish:	Significance of Goal: (ex. I want to be able to golf on a family vacation this summer)

I agree to assume responsibility for any charges created by my chiropractic care, and give consent to be examined and/or treated by Dr. Woodward and her staff.

Patient Signature____ Date:__________