Central Clinic
Of Chiropractic

Central Clinic of Chiropractic
11 E Calhoun St Sumter, SC
29150 (803) 757-1700

**Please fill out the application entirely and legible. We need all information for insurance purposes.**

**Name** _____ **Nick Name** _____

**Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Phone** _____ **Email** _____

**We need to contact you both by phone and email. Please be sure to give us the best phone number to reach you**

**Date of birth** _____ **Social Security** _____

**If you have Medicare, we need you to list your SSN above or provide us with the Medicare card**

**Your Occupation** _____ **Retired** Yes ☐ No ☐

## REVIEW OF SYMTOMPS

**Please check all that apply**

- ☐ Headache
- ☐ Migraines
- ☐ Ear Pain
- ☐ Jaw Pain (TMJ)
- ☐ Osteoporosis
- ☐ Shoulder Pain
- ☐ Upper Back Pain
- ☐ Knee Pain
- ☐ Rheumatoid Arthritis
- ☐ Vertigo/Dizziness
- ☐ Gastrointestinal Disorder
- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Implanted Cord / Bladder Stimulator
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Plantar Fasciitis
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacment
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination

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## PRESENT HEALTH CONDITION

**01** **Please list your health concerns in order of priority:**

**02** **Is there a certain time of day any of these problems are better or worse?**

**03** **Is your balance/walking ability affected? If yes, please describe:**

**04** **List approximately how long you have noticed these problems in your life:**

**05** **Circle the things you have used for these problems:**

Gabapentin Aleve Heat Injections Acupuncture Tylenol Ice Creams

Ibuprofen Physical Therapy Chiropractic Opioid/Pain Prescription Massage Therapy Over-the-counter pain medication

**06** **What do you think is causing your problem?**

**07** **Name all of doctors you have seen for these problems and treatment your received:**

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**08** **Have your symptoms:** Improved ☐ Worsened ☐ Stayed the same ☐

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

**09** **How would you describe the symptoms? Please check ALL that apply:**

| | | |
|---|---|---|
| ☐ Aching Pain | ☐ Tingling/Electric Shocks | ☐ Dead Feeling |
| ☐ Stabbing Pain | ☐ Pins & Needles Pain | ☐ Cold Hands/Feet |
| ☐ Sharp Pain | ☐ Heavy Feeling | ☐ Cramping |
| ☐ Tiredness | ☐ Hot Sensation | ☐ Swelling |
| ☐ Numbness | ☐ Throbbing Pain | ☐ Burning |

**10** **Is this condition interfering with any of the following?**

| | | |
|---|---|---|
| ☐ Sleep | ☐ Work | ☐ Daily Activities |
| ☐ Recreational Activities | ☐ Walking | ☐ Standing |

## SOCIAL HISTORY

**Do you smoke?** Yes ☐ No ☐ If yes, how many cigarettes daily? _____

**Do you drink?** Yes ☐ No ☐ If yes, how many drinks per week? _____

**Do you exercise?** Yes ☐ No ☐ If yes, please describe type and how often?

_____

## CURRENT PAIN LEVELS

**Please indicate your daily level of pain.**

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

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## PREVIOUS HEALTH CONDITION

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

**Name** _____ **Signature** _____

Please give name, address, and office phone number of your primary care physician.

**Name** _____ **Phone** _____ **Address** _____

**When were you last seen there?** _____

**May we send them updates on your treatment/condition?** Yes ☐ No ☐

**List ALL allergies/sensitivities to medication, food, and other items here:**

| Items you react to: | Reaction: |
|---|---|
| | |
| | |
| | |
| | |

**List the prescription drugs you are currently taking (or you may attach a list):**

| Name | Dose (mg or IU) | Time Daily |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**List any past surgeries, date, and relevant details:**

| Surgery | Date | Notes/Details |
|---|---|---|
| | | |
| | | |
| | | |

**List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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**Name** _____ **Date** _____

Please take several minutes to answer these questions so we can help you better.
**Please check all that apply**

**01** **How have you take care of your health in the past?**

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Others (please specify) _____

**02** **How did the previous methos(s) work out for you?**

- ☐ Bad Results
- ☐ Some Results
- ☐ Good Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

**03** **How have others been affected by your health condition?**

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

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**04** **What are you afraid this might be (or beginning) to affect (or will affect)?**

- [ ] Job
- [ ] Kids
- [ ] Future Ability
- [ ] Marriage
- [ ] Self-Esteem
- [ ] Sleep
- [ ] Time
- [ ] Finances
- [ ] Freedom

**05** **Are there health conditions you are afraid this might turn into?**

- [ ] Family Health Problems
- [ ] Heart Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Depression
- [ ] Chronic Fatigue
- [ ] Need Surgery

**06** **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

**07** **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

**1.** _____

**2.** _____

**3.** _____

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**08** **What are you most concerned with regarding your problem?**

**09** **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

**10** **What would be different/better without this problem? Please be specific.**

**11** **What do you desire most to get from working with us?**