REVOLUTION
HEALTH CENTER
Chiropractic • Fitness • Nutrition

Application for Care

546 Brandies Circle, Suite 103
Murfreesboro, TN 37128
PH: 615-867-7693 | FAX: 615-867-7695

Today's Date: ________________ Who Referred You? ___________________________ HRN: __________________

PATIENT DEMOGRAPHICS

Name: ______________________________________ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: ____________________________________ City: ____________________________ State: _____ Zip: _________

E-mail Address: ______________________________ Home Phone: ________________ Mobile Phone:______________

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: ________________________

Social Security #: ______________________________ Driver's License #: ______________________________________

Employer: ___________________________________ Occupation: ____

Spouse's Name: ________________________________ Spouse's Employer _____________________________________

Number of children and Ages: _____________________________

Name & Number of Emergency Contact: __________________________________ Relationship: _______________________

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: ____
Secondarily: _______________________ Third: __________________________ Fourth: _______________________________

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number***:

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

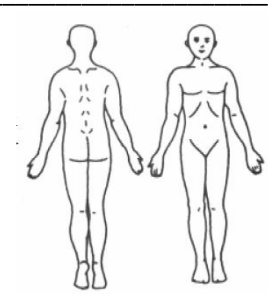
When did the problem(s) begin? __________________ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?__________

Condition(s) ever been treated by anyone in the past? ☐No ☐ 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 Diagram with the following **letters** to describe your symptoms:
R = Radiating **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 them feel worse? _______________________________

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
______________________________:	______________________________	______________________________
______________________________:	______________________________	______________________________
______________________________:	______________________________	______________________________

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

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _________ _ When was the last episode? ______________________ How did the injury happen?____________

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: ___________________________________, and who provided it: __________________________ **How long ago? _______**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. ____ _____________________________________

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past***, **C** for ***Currently*** have and **N** for *Never have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: ___________________________

I hereby authorize payment to be made directly to **Revolution Health Center**, 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 **Revolution Health Center** for any and all services I receive at this office.

____ ______ - ______ - _____
Patient or Authorized Person's Signature **Date Completed**

____ ______ - ______ - _____
Doctor's Signature **Date Form Reviewed**

Patient's Name: _____________________________ HR#: _________________ ___/___/___ **JDD,DC 5/2011**

Activities of Daily Living/Symptoms/Medications

Patient Name: ____________________________________ File#____________

Date: _______________________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:____

____

____

Patient Name_______________________________ File#/HRN ____________Date________

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at **Revolution Health Center** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

Revolution Health Center *NOTICE REGARDING YOUR RIGHT TO PRIVACY and OFFICE POLICIES*

I have been offered a copy of Revolution Health Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received. This signature below is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'.

Also, I hereby acknowledge that I have been offered a copy of the practices 'Office Policies'. I am aware that a more comprehensive version of the "Office Policies" is available to me and several copies kept in the reception area. This signature below is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding the "Office Policies'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

____ ______________ ____________

Patient's Name DOB HR#

____ ______________

Patient signature Date

____ ______________

Witness Date

JDD,DC 5/2011