A.Nickel Chiropractic
Alexandrea Nickel D.C.

Application for Care

Date: _____

Patient Demographics

Name: _____ Birthdate: _____/_____/_____ Age: _____ ☐ M ☐ F

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Best Phone # for contact: _____

Marital Status: M S D W # of children: _____ SSN _____

Occupation: _____ Primary Care Physician: _____

Insurance Information Do you have insurance? ☐ Yes ☐ No

Name of Primary Insurance: _____ Subscribers Name: _____

Name of Secondary Insurance: _____ Subscribers Name: _____

In Case of Emergency Name & Phone Number:_____

History of Complaint

Is the issue the result of a: ☐ Car Accident ☐ Work Injury Date of Injury: _____

Rate your pain level at its **WORST**

Major Complaint: _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

Other complaint: _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

How long have you had this issue? _____

What makes your condition better? _____worse? _____

Does the pain travel? _____ Where does it travel? _____

How long does it last? ☐Constant ☐ On/off (☐ 25% of day ☐ 25-50% of day ☐ 50-75% of day ☐75-100% of day)

Have you been to a chiropractor before? ☐ No ☐ Yes Have you ever had x-rays? _____

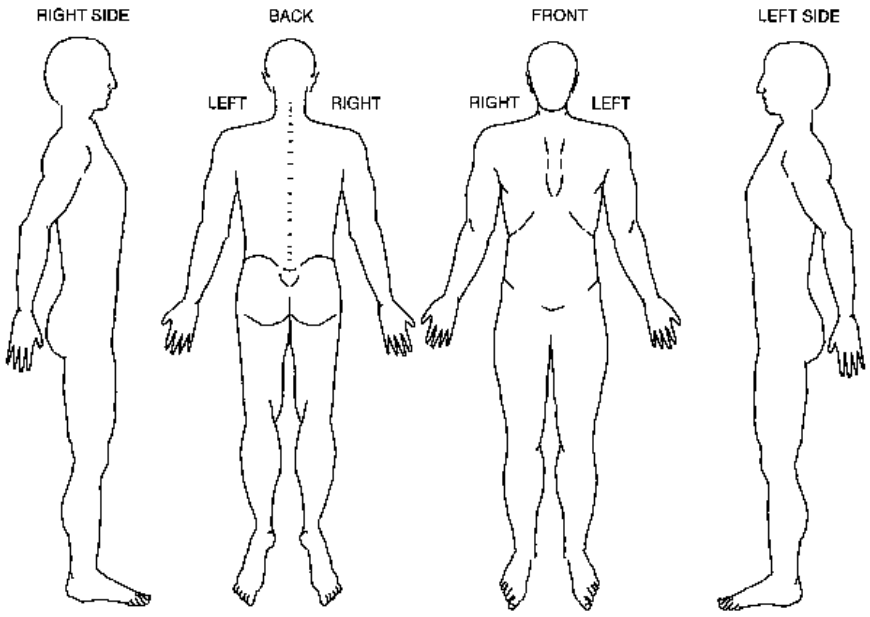
Are you taking any medications? ____ Name and dose?_____

Other forms of treatment tried? ☐ No ☐ Yes If Yes, what type of treatment? _____

What were the results ☐ favorable? ☐ unfavorable?

Put an X where ALL of your pain/ sensations are and label what it feels like

A=Aching
B=-Burning
St=Stabbing
D=Dull
N=Numbness
P=Pins and needles
DP=Deep



Patient/ Parent or Guardian Signature: _____Date: _____

PAST HISTORY

Select if you currently have or have ever been diagnosed with any of the following conditions:

_____arthritis/bursitis _____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis
_____diabetes _____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension
_____heart attack /disease / failure _____ kidney stones ____high cholesterol _____pacemaker
_____kidney issue _____leg swelling _____liver problems _____murmur _____ pneumonia _____reflux
_____ Rheumatoid arthritis _____sleep apnea _____ stroke _____thyroid issue_____ tuberculosis
_____whiplash _____sprains _____HIV _____Paget's disease _____ Varicose Veins _____ tumors_____ ulcer
_____ Muscular dystrophy _____multiple sclerosis _____broken bones in the last 2 years _____ dislocations
_____accidents (last 2 years) _____ osteoarthritis
_____ Allergies (_____ food _____ seasonal _____ Other: _____)
_____Surgery: Where?/When? _____

SOCIAL HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarette ☐ E -cigarette/Vape
How much_____ How often? ☐ Daily ☐ Weekends ☐ occasionally ☐ never
Alcoholic Beverages: How much _____ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
Recreational drugs :_____ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
How well do you sleep? ☐ Good ☐ Fair ☐ Poor Interruptions ? ☐ Yes ☐ No How many times/night?_____

FAMILY HISTORY Does anyone in your family suffer with these conditions? Check if applicable.

_____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis _____diabetes_____ dialysis
_____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension _____murmur
_____heart attack/ disease/ failure _____hemophilia _____ kidney stone _____ Varicose Veins
____high cholesterol _____kidney issue _____liver issues _____ obesity _____pacemaker ____Rheumatoid arthritis
_____sleep apnea _____ stroke _____thyroid issue _____ tuberculosis _____Paget's disease _____ ulcer
_____ Muscular dystrophy _____multiple sclerosis_____ tumors
_____ Allergies (_____ food _____ seasonal _____other:_____)
_____ Other unlisted conditions: _____

ACTIVITY OF DAILY LIVING Explain how your condition is affecting your ability to perform activities

1. Carrying weight? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
2. Sitting to Standing ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
3. Climbing stairs? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
4. Computer/ Phone use? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
5. Reading? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
6. Getting dressed? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
7. Sexual activities? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
8. Sleep? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
9. Sitting? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
10. Yard work? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
11. Walking? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
12. Washing/Bathing/ Hygiene? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
13. House chores? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
14. Driving? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
15. Hobbies? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) Can't perform
16. Other? _____ ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform

These statements made on this form are accurate to the best of my recollection and I agree to allow **A. Nickel Chiropractic** to examine me for further evaluation. _____ **Initials**

Patient/ Parent or Guardian Signature: _____Date: _____