Whom may we thank for referring you to this office → _____

APPLICATION FOR CARE at Sowing Wellness

Today's Date: _____ 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: Pre-Natal Care_____
Secondarily: _____ _____ Third: _____ Fourth: _____

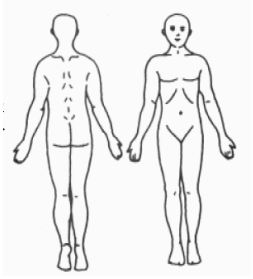
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 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? __Helpful_____

Name of Previous Chiropractor: ___Dr. Goodson_____ ☐ **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: _____

CURREN6T 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 Sowing Wellness Business Solutions LLC, 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 [CLINIC NAME] 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#: _____ Date: _____

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: _____

occasion_____

_____

_____

Patient Name_____ File#/HRN _____Date_____

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____
What speed was the collision? _____
Type of impact: Front Impact / Side Impact / Rear Impact
Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____
Please describe the manner of the injury _____
Was treatment received? Please describe _____
Does your job require you remain in long term stressful postures?_____
(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____None_____
Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____
Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____
Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) _____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _____

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0 (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

_____
_____
_____

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____What is your current weight?

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Doctor Signature ___________________________________Date____________________