ABUNDANTYOU
CHIROPRACTIC & WELLNESS CENTER

NEW PATIENT APPLICATION

WHOM MAY WE THANK FOR REFFERING YOU TO OUR OFFICE:_____ **TODAYS DATE:** _____

PATIENT DEMOGRAPHICS:

Name: _____
Birth Date: _____-_____-_____ Age: _____ ❑ M ❑ F
Address: _____
City: _____State: _____ Zip: _____
Social Security:_____
Email: _____
Mobile#: _____
Occupation: _____

Marital Status:❑Single ❑Married ❑Widowed ❑Divorced ❑Engaged
Name of Spouse: _____
Occupation: _____
Mobile#: _____
How many children do you have :_____
Emergency Contact:_____
Relationship: _____Phone#:_____

INSURANCE INFORMATION:

Do you have Medicare? ❑ Y ❑ N

Do you have health insurance? ❑ Y ❑ N

Primary Company_____ Policy #:_____

Secondary Company_____ Policy #:_____

HISTORY OF COMPLAINT:

1. Please identify the condition(s) that brought you to our office:
   1st: _____ 2nd: _____ 3rd: _____

2. On a scale of 0-10 (0 = no pain and 10 = worst pain), rate your above complaints, by checking the number **THAT APPLIES**:
   1st : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   2nd: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
   3rd : ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

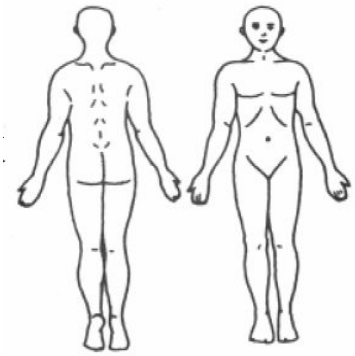
3. When did the complaint(s) begin? _____ When is the complaint(s) the worst? ❑ AM ❑ Mid-Day ❑ PM

4. How did the "injury" (complaint) happen? _____

5. How long does it last? ❑ It is constant ❑ I experience it on and off during the day ❑ It comes and goes throughout the week

DESCRIBE YOUR SYMPTOMS:

PLEASE MARK the areas on the diagram with the following LETTERS:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness
S = Sharp/Stabbing **T** = Tingling ⟶



PAST HISTORY:

1. Have you suffered with 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? _____

2. Other forms of treatment tried? ❑ No ❑ Yes – If yes, please state what type of treatment: _____
   and who provided treatment: _____ How long ago? _____
   What were the results? ❑ Favorable ❑ Unfavorable – Please explain: _____

3. Have you ever seen a chiropractor? ❑ No ❑ Yes – If yes, what were the results? ❑ Bad ❑ Good ❑ Great

ACTIVITIES OF DAILY LIVING:

1. No effect 3. Painful (activities limited)
2. Painful (can do) 4. Unable to perform

Bending	☐ 1	☐ 2	☐ 3	☐ 4
Carrying	☐ 1	☐ 2	☐ 3	☐ 4
Climbing	☐ 1	☐ 2	☐ 3	☐ 4
Computer work	☐ 1	☐ 2	☐ 3	☐ 4
Concentrating	☐ 1	☐ 2	☐ 3	☐ 4
Dancing	☐ 1	☐ 2	☐ 3	☐ 4
Doing Chores	☐ 1	☐ 2	☐ 3	☐ 4
Dressing	☐ 1	☐ 2	☐ 3	☐ 4
Driving	☐ 1	☐ 2	☐ 3	☐ 4
Gardening	☐ 1	☐ 2	☐ 3	☐ 4
Lifting	☐ 1	☐ 2	☐ 3	☐ 4
Playing Sports	☐ 1	☐ 2	☐ 3	☐ 4
Pushing	☐ 1	☐ 2	☐ 3	☐ 4
Reading	☐ 1	☐ 2	☐ 3	☐ 4
Recreational Activities	☐ 1	☐ 2	☐ 3	☐ 4
Rolling Over	☐ 1	☐ 2	☐ 3	☐ 4
Running	☐ 1	☐ 2	☐ 3	☐ 4
Sexual Activity	☐ 1	☐ 2	☐ 3	☐ 4
Shoveling	☐ 1	☐ 2	☐ 3	☐ 4
Sitting	☐ 1	☐ 2	☐ 3	☐ 4
Sitting to Standing	☐ 1	☐ 2	☐ 3	☐ 4
Sleeping	☐ 1	☐ 2	☐ 3	☐ 4
Standing	☐ 1	☐ 2	☐ 3	☐ 4
Walking	☐ 1	☐ 2	☐ 3	☐ 4
Watching TV	☐ 1	☐ 2	☐ 3	☐ 4
Working	☐ 1	☐ 2	☐ 3	☐ 4

SYMPTOMS:

Please check all that apply in **past 12 months.**

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Bed Wetting
- ❑ Blood Pressure (High or Low)
- ❑ Blurred Vision
- ❑ Broken Bones/Fractures
- ❑ Cancer
- ❑ Colon Trouble/Digestive Issues
- ❑ Depression
- ❑ Diarrhea/Constipation
- ❑ Difficulty Breathing
- ❑ Dizziness/Loss of Balance
- ❑ Double Vision
- ❑ Eating Disorder
- ❑ Epilepsy/Convulsions
- ❑ Fainting
- ❑ Foot or Knee Problems
- ❑ Frequent Colds/Flu
- ❑ Gall Bladder Trouble
- ❑ Headaches
- ❑ Hearing Loss
- ❑ Heartburn
- ❑ Heart Problem
- ❑ Hepatitis (A,B,C)
- ❑ Hormone Imbalance
- ❑ Impotence/Sexual Dysfunction
- ❑ Irritable
- ❑ Jaw pain/TMJ
- ❑ Kidney Trouble
- ❑ Learning Disability
- ❑ Liver Trouble
- ❑ Lung Problems
- ❑ Menopausal Problems
- ❑ Mood Changes
- ❑ Numb/Tingling arms, hands, fingers
- ❑ Numb/Tingling legs, feet, toes
- ❑ Osteoporosis
- ❑ Pain CHEST
- ❑ Pain HIP
- ❑ Pain LOW BACK
- ❑ Pain MID BACK
- ❑ Pain NECK
- ❑ Pain SHOULDER
- ❑ Pain UPPER BACK
- ❑ Painful Swollen joints
- ❑ Pregnant (now)
- ❑ Prostate Problems
- ❑ Ringing in Ears
- ❑ Scoliosis
- ❑ Sinus/Drainage Problem
- ❑ Skin Problems
- ❑ Swollen/Painful Joints
- ❑ Tremors
- ❑ Trouble Sleeping
- ❑ Tumors
- ❑ Ulcers

ARE YOU TAKING MEDICATIONS FOR ANY OF THE FOLLOWING:

❑ Acid Reflux	❑ Anxiety	❑ Cholesterol	❑ Hormone Therapy (HRT)	❑Thyroid
❑ ADD/ADHD	❑ Aspirin	❑ Crohns/Colitis	❑ Ibuprofen	❑Tylenol
❑ Allergy	❑ Birth Control	❑ CPAP machine	❑ Muscle Relaxer	❑_____
❑ Anti-biotics	❑ Blood Pressure	❑ Diabetes	❑ Pain Killer	❑_____
❑ Antidepressants	❑ Blood Thinner	❑ Headache	❑ Sleep	❑_____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same complaint(s)? ❑ No ❑ Yes
   If Yes, whom? ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Daughter ❑ Son
2. Have they ever been treated for the same condition(s)? ❑ No ❑ Yes ❑ I don't know
3. Any other hereditary conditions the Doctor should be aware of? ❑ No ❑ Yes: If yes, Explain: _____

SOCIAL HISTORY:

1. Smoking: ❑ Cigars ❑ Pipe ❑ Cigarettes >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverages (Consumption): >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug Use: >> How often: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How does your present complaint affect your recreational activities/exercise regime/hobbies? _____
   _____

THE EVANS ASSESSMENT

PATIENT NAME: _____ **DATE:**_____

PHYSICAL STRESS:

1. Have you ever been in a car accident? ❑ No ❑ Yes - If yes when? _____
   a. What speed was the collision? ❑ 0 - 10 ❑ 10 - 20 ❑ 20 - 30 ❑ 40 - 50 ❑ 50+
   b. Type of impact: ❑ Front Impact ❑ Side Impact ❑ Rear Impact ❑ Roll-Over
   c. Was treatment received? ❑ No ❑ Yes – If yes, explain: _____
2. Have you ever been injured at work? ❑ No ❑ Yes – If yes, explain: _____
   a. Was treatment received? ❑ No ❑ Yes – If yes, explain: _____
   b. Does your job require you to remain in long-term stressful postures? ❑ No ❑ Yes
   (*i.e. all day seating, repeated lifting, long-term computer use)*
3. Have you ever had any spinal traumas in the past? ❑ No ❑ Yes – If yes, explain: _____
   a. Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field (explain) :_____
   b. Trauma as a child: fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident, sports injury (explain):_____
   c. Work around the house: (lifting, bending, woke up with stiff neck, "back went out") (explain):
   _____

STRESS PROFILE:

1. How many hours of sleep do you average per night? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑7 ❑ 8 ❑ 9 ❑ 10+
2. Do you have trouble falling asleep ❑ Wake up and can't fall back asleep ❑ Wake up exhausted like you never slept ❑
3. Do you ever take pills to go to sleep or relax? ❑ No ❑ Yes
4. Do you use a CPAP machine? ❑ No ❑ Yes
5. Do you often feel short on time and procrastinate on projects? ❑ No ❑ Yes
6. Do you feel like you don't give enough time to important areas in your life like family, personal , or a hobby? ❑ No ❑ Yes

CHEMICAL STRESS PROFILE:

1. Are you regularly exposed to cleaning products or industrial chemicals? ❑ No ❑ Yes
2. Have you ever noticed mold growing in your home or your place of work? ❑ No ❑ Yes
3. Does your home, work, school, or car have damp or mildew smell? ❑ No ❑ Yes

FITNESS PROFILE:

1. What type of exercise do you practice? ❑ Cardio ❑ Weight training ❑ Yoga ❑ Burst ❑ Organized sports ❑ Triathlons
2. Where do you workout? ❑ Gym ❑ Home ❑ Group Class ❑ Don't workout
3. How long do you exercise Minutes ❑ 0-30 ❑ 30-60 ❑ 60-90 ❑ 90+
4. How often do you exercise Days per Week ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. What is your goal? ❑ Weight ❑ Muscle ❑ Fitness ❑ Energy ❑ Image
6. What is your current weight? _____ What is your target weight? _____

NUTRITIONAL PROFILE:

1. Do you eat breakfast daily from Monday to Friday? ❑ No ❑ Yes
2. How many days per week do you skip one meal? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
3. How many fast food, refined foods, or pre-pared meals do you eat per week? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
4. How many servings of fruit do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
5. How many servings of vegetables do you have on a given day? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7
6. Do you regularly drink (1 or more per day) ? (check all that apply) ❑ Soda ❑ Coffee ❑ Juice ❑ Milk ❑ Alcohol
7. Please list any supplements you take regularly: _____

   _____
8. Please list any allergies or sensitivities: _____

WHAT DO YOU FOCUS ON WHEN SELECTING FOODS?

(check all the apply):

- ❑ Calorie Content
- ❑ Fat Content (low fat diet)
- ❑ Ingredient list
- ❑ Sodium levels
- ❑ Artificial Sweeteners
- ❑ Ratio: Fat, Protein, Sugar
- ❑ Fat content (low fat)
- ❑ Nutrition data label
- ❑ Gluten content
- ❑ Pasteurization (milk)
- ❑ Glycemic Index
- ❑ Sugar content
- ❑ MSG content
- ❑ FDA food pyramid

WHAT TYPE OF FOOD DO YOU BUY?

(check all the apply):

- ❑ Organic Vegetables
- ❑ Grass-fed beef
- ❑ Wild-caught fish
- ❑ Non-GMO food
- ❑ Wild/Free range poultry
- ❑ Fresh fruit
- ❑ Healthy snacks
- ❑ Almond/coconut milk
- ❑ Water
- ❑ Regular Vegetables
- ❑ Grain-fed beef
- ❑ Farm raised fish
- ❑ GMO food/don't know
- ❑ Unknown source of poultry
- ❑ Canned Preserved fruit
- ❑ Junk food snacks
- ❑ Cow/soy milk
- ❑ Soda/Sweet tea/Coffee

DO YOU FOLLOW A NAMED DIET OR DOCTOR'S PLAN?

(check all the apply):

- ❑ Blood Type
- ❑ GAPS
- ❑ Paleo
- ❑ Raw Food
- ❑ Vegetarian
- ❑ Zone Diet
- ❑ Other _____
- ❑ Atkins
- ❑ Mediterranean
- ❑ Nutrisystem
- ❑ South Beach
- ❑ Volumetrics
- ❑ Weight Watchers
- ❑ None

WHAT DO YOU TYPICALLY EAT FOR BREAKFAST?

(check all the apply):

- ❑ Eggs
- ❑ Fruit
- ❑ Smoothie
- ❑ Vegetables
- ❑ Vegetarian
- ❑ Other_____
- ❑ Cereal
- ❑ Oatmeal
- ❑ Packaged meats
- ❑ Pastries
- ❑ Toast
- ❑ Other_____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW?

_____

_____

_____

_____

Dr. Kevin would like to invite you to receive healthy daily tips on Facebook. Would it be ok with you, if we invite you to like our fan page to gain this access?

- ❑ Yes
- ❑ No

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.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Abundant You Chiropractic & Wellness will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Abundant You Chiropractic & Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment.

Treatment Objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Abundant You Chiropractic & Wellness 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 Guardian's Signature Date

X-RAY CONSENT

REGARDING: X-rays/Imaging Studies

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 if the doctor has deemed necessary in my case.

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 mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ _____ *Witness Initials*

Patient or Guardian's Signature Date

NOTICE OF PRIVACY PRACTICE

I have been offered a copy of the office Patient Privacy Notice, I understand my rights as well as the practice's 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 front desk. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name (Printed) DOB

_____ _____ *Witness Initials*

Patient or Guardian's Signature Date