APPLICATION FOR ADMISSION Date _____ **DaySpring Family Wellness Center**

Name _____ □M □F Birthdate _____ Age ____

Address _____City _____ State _____ Zip _____

Home Phone _____Cell _____ Appt. Reminders- Cell□ Email□

Cell Phone Carrier _____ E-mail Address _____

Significant Other's Name _____

Names and Ages of Children_____

Your Employer _____Type of Work_____

Emergency Contact Person _____Phone _____

Name of Medical Doctors:_____

If you have had an MRI, list when and where it was taken: _____

How did you hear about DaySpring? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I understand that I am responsible for all bills incurred for services.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- If female and need X-rays, I agree that I AM NOT PREGNANT.
- Information on the privacy of my Personal Health Information is available from the doctor.
- For my balance, my preferred method of payment is: □Cash □Check □Credit Card

Signature _____ Date _____

REASON FOR SEEKING CARE

What is the problem that you are seeking care for?_____

How long has this been an issue?_____

Does your condition affect: □sleep □work □daily routine □sitting □driving

Is it worse in the: □morning □mid-day □evening □doesn't matter

Is the pain: □dull or □sharp

How often are you aware of it? □occasionally □ 50% of the time □75% of the time □constantly

What makes you feel better? _____

What makes you feel worse? _____

Previous treatments □shots: when _____ □pain pills/relaxants: when _____

□therapy: when _____ □chiropractic: when _____

□surgery: when _____ □other: _____ when _____

What do you think the problem is? _____

_____

Do you consider your problem: □mild □moderate □severe □extreme

What activities bother you because of your problem:

_____

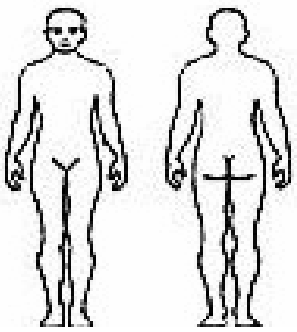
Have you lost time from work? □yes □no

Have you lost time from family/friends? □yes □no

What are you hoping we can do for you?

_____

(X) Mark Areas of Concern



GENERAL HEALTH HISTORY

DaySpring Family Wellness Center

Patient Name _____ Mark the conditions that apply to you.

Past	Present		Past	Present	
☐	☐	Neck Pain	☐	☐	Urinary Problems
☐	☐	Headaches/Migraines	☐	☐	Easy Bruising
☐	☐	Arm-Hand Pain/Numbness/Tingling	☐	☐	Tobacco Use
☐	☐	Pain Between Shoulders	☐	☐	Shortness of Breath
☐	☐	Low Back Pain	☐	☐	Allergies/Asthma
☐	☐	Leg/Foot Numbness/Tingling	☐	☐	Dental Problems/TMJ
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner Use
☐	☐	Hands or Feet Cold	☐	☐	HIV Positive
☐	☐	Muscle Aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Hip/Knee Replacement	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	High Blood Pressure
☐	☐	Gall Bladder Problems	☐	☐	Stroke History
☐	☐	Ringing in the Ears/Ear Problems	☐	☐	High Cholesterol
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems/Light Bothers Eyes	☐	☐	Pain All Over
☐	☐	Thyroid Problems	☐	☐	Tension/Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Problems/Pacemkr

Is this visit due to a work injury? ☐Y ☐N Injury Date _____ Car Accident ☐Y ☐N Injury Date _____

List all if the medications that you are taking:_____

_____

List all of the doctors that you are currently seeing: _____

_____

Notes:_____

PAST HISTORY

List any past auto collisions: _____ ☐received care ☐no care

List any past work injuries: _____ ☐received care ☐no care

List any past sport, recreational, or home injuries:_____

Please describe any past conditions and treatments received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: ☐Heart Disease ☐Cancer ☐Diabetes ☐Heavy Medication use ☐Arthritis ☐Other _____

Mother's side: ☐Heart Disease ☐Cancer ☐Diabetes ☐Heavy Medication use ☐Arthritis ☐Other _____

Is there any other family history that you would like us to know about?_____

_____