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

APPLICATION FOR CARE WITH DR. SAMANTHA JENNINGS, DC

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____o Male o Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: Single Married Widowed Divorced Separated

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 ***circling 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? o AM o PM o mid-day o 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?

_____

_____

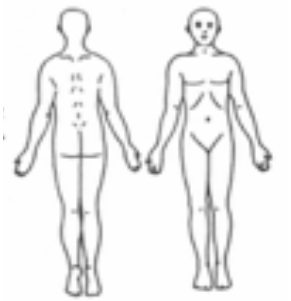
Condition(s) ever been treated by anyone in the past? □No □ Yes **If yes,** when: _____ by whom?

_____

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? _____

Is your problem the result of ANY type of accident? o Yes, o 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: o No o Yes
If yes, please state **what** type of treatment: _____

and who provided it: _____ **How long ago? _____**

What were the results? o Favorable o 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 *N**ever** have had*:
___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability

___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral Vascular/Stroke ___Cancer

___ 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 ❑ e-cig/vape **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:

_____

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 Dr. Samantha Jennings, DC, 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 Dr. Samantha Jennings, DC 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#: _____ ___/___/___