CHAMPION wellness centers Of Valrico

4341 Lynx Paw Trail

Valrico, FL 33596
Ph: 813-409-3304 Fax: 813-409-3772

APPLICATION FOR CARE

Date: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Age: _____ SSN: _____ Marital Status: S M D W

Occupation: _____ # of Children: _____ Spouse's Name: _____

Name & Number of Emergency Contact: _____

Relationship: _____ Do you have insurance? ☐ Yes ☐ No

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office (in order of severity), and circle your level of pain on a scale of **1** to **10** (zero = no pain; 10 = worst pain)

1. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

2. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

3. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

4. _____ Pain Level: 0 1 2 3 4 5 6 7 8 9 10

When did the problem(s) begin? _____

When is the problem at its worst? ☐ early AM ☐ mid-morning ☐ mid-day ☐ early evening ☐ late evening

How long does it last? ☐ constant throughout day ☐ I experience it on and off during the day

☐ it comes and goes throughout the week

How did the injury happen? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Has the condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No

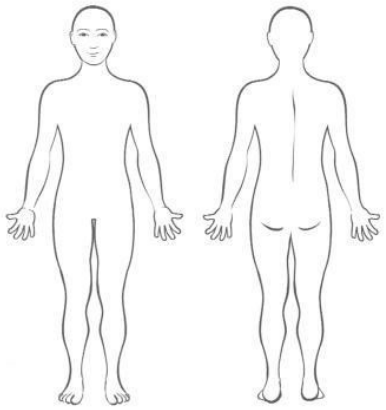
If yes, when: _____ and by whom? _____

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 = **R**adiating
B = **B**urning
D = **D**ull
T = **T**ingling
A = **A**ching
N = **N**umbness
S = **S**harp/**S**tabbing



What relieves your symptoms? _____
What makes them feel worse? _____

Please list any restricted activities, your current activity level, and your usual activity level:

RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
ex: walking	*ex: walk half mile 2x/week*	*ex: walk one mile 4x/week*

Identify any other injuries to your spine, minor or major, that the doctor should know about: _____

Please list **all** prescription medications (and their purpose) and non-prescription medications/vitamins/supplements you are currently taking: _____

Women: Is there ***any chance*** that you are pregnant? ☐ Yes ☐ No

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? □ Yes □ No

If yes, how many times? _____ When was the last episode? _____

How did the injury happen? _____

Have you tried any other forms of treatment: □ Yes □ No

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, activities, or events you have experienced 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:

P = in the **P**ast **C** = **C**urrently **N** = **N**ever have had:

___ broken bone	___ disability	___ cancer	___ rheumatoid arthritis
___ osteoarthritis	___ diabetes	___ cerebrovascular	___ heart attack
___ dislocations	___ tumors	___ thyroid disorder	___ other: _____

Please identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	Condition	How Long Ago	Type of Care Received	By Whom
INJURIES				
SURGERIES				
CHILDHOOD DISEASES				
ADULT DISEASES				

SOCIAL HISTORY

1. Smoking: □ cigars □ pipe □ cigarettes □ daily □ weekends □ occasionally □ never
2. Alcoholic beverage consumption: □ daily □ weekends □ occasionally □ never
3. Recreational drug use: □ daily □ weekends □ occasionally □ never
4. Hobbies/recreational activities/exercise/sports: _____

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? □ Yes □ No

   If **yes** whom: □ grandmother □ grandfather □ mother □ father □ sibling(s) □ son(s) □ daughter(s)

   Have they ever been treated for their condition? □ Yes □ No □ I don't know

2. Any other hereditary conditions the doctor should be aware of? □ No □ Yes: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the source for each complaint (see example below).

Example:

			Headache			Neck			Low Back			
No pain	**0**	**1**	(**2**)	**3**	**4**	(**5**)	**6**	**7**	(**8**)	**9**	**10**	Worst Possible Pain

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1. What is your pain level **right now**?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain

2. What is your **typical** or **average** level of pain?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain

3. What is your pain level **at its best** (how close to "0" does your pain get at its best)?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain

4. What is your pain level **at its worst** (how close to "10" does your pain get at its worst)?

No pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Worst Possible Pain

Other Comments: _____

_____

_____

OATS Score: _____ %

ACTIVITIES OF DAILY LIVING

Please identify how your current condition(s) is affecting your ability to carry out activities that are routinely part of your life.

Reading/Concentrating	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Shaving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Taking out Garbage	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Rolling Over	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carrying (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting (groceries, children, etc.)	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard Work	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Bending	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sitting	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Standing	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sit to Stand Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Stand to Sit Position	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dishes	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Laundry	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other:	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
	□ N/A	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

Please mark the listed items below as: **P** (Past) **C** (Currently) **N** (Never)

____ headache
____ neck pain
____ jaw pain, TMJ
____ shoulder pain
____ upper back pain
____ mid back pain
____ low back pain
____ hip pain
____ back curvature/scoliosis
____ numb/tingling arms
____ numb/tingling hands/fingers
____ numb/tingling legs
____ numb/tingling feet/toes
____ knee problems
____ foot problems
____ swollen/painful joints
____ frequent colds/flu
____ pain w/ cough/sneeze
____ allergies
____ sinus/drainage problem

____ convulsions/epilepsy
____ tremors
____ dizziness
____ loss of balance
____ fainting
____ double vision
____ blurred vision
____ ringing in ears
____ hearing loss
____ asthma
____ difficulty breathing
____ lung problems
____ heart problems
____ heartburn
____ chest pain
____ high blood pressure
____ low blood pressure
____ ulcers
____ digestive problems
____ colon trouble

____ diarrhea/constipation
____ kidney trouble
____ gallbladder trouble
____ liver trouble
____ prostate problems
____ impotence
____ menstrual problems
____ PMS
____ menopausal problems
____ depression
____ irritable
____ bed wetting
____ skin problems
____ mood changes
____ learning disability
____ ADD/ADHD
____ eating disorder
____ trouble sleeping
____ Hepatitis (A, B, C)
____ other: _____

I hereby authorize payment to be made directly to Champion Wellness Centers of Valrico 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 affecting 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 Champion Wellness Centers of Valrico for any and all services I receive at this office that are not covered under a healthcare plan.

_____ _____
Signature of Patient or Authorized Person Date

_____ _____
Signature of Doctor Date

Notes: _____