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

APPLICATION FOR CARE AT *PATH Wellness*

DATE: _____ **VRC#:** _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ Male ☐ Female

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

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

Social Security #: _____ - _____ - _____ Driver's License #: _____

Employer: _____ Occupation: _____ Work Phone: _____

Do you have Insurance: ❑ Yes ❑ No Provider Name: _____ Member ID#: _____

Marital Status: ❑ Single ❑ Married Spouse's Name _____

Do you have any children? **Y / N** No. of children: _____ Ages: _____

Name & Number of Emergency Contact: _____ / _____ Relationship: _____

HISTORY of COMPLAINTS

Please identify the condition(s) that brought you to this office:

Primary: _____ Second: _____

Third: _____ Fourth: _____

On a scale of **1** to **10** with **zero** being no pain and **10** being the worst pain - rate your above complaints by ***circling the number below*:**

Primary complaint 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Second complaint 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

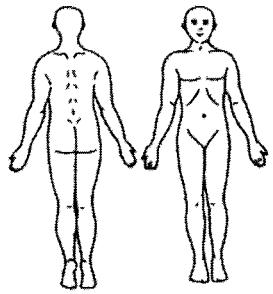
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

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

How did the injury happen? _____

PLEASE MARK THE AREAS ON THE DIAGRAM WITH THE FOLLOWING TO DESCRIBE YOUR SYMPTOMS:

R = **R**adiating **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 ANY RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes,** when? _____
When was the last episode? _____ How did the injury happen? _____
Did you try other forms of treatment? ☐ No ☐ Yes
If yes, please state ***what type of treatment***: _____
Who provided it? _____ How long ago? _____

Please identify ALL types of jobs/activities that you have had in the past that have imposed any physical stress on you or your body:

_____

Please identify all PAST and CURRENT conditions you feel may be contributing to your present problem:
SPINAL INJURIES →
SURGERIES →
CHILDHOOD DISEASES →
ADULT DISEASES →

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes ❑vape → Consumption occurs how often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: Consumption occurs how often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: Consumption occurs how often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Recreational Activities/Exercise Regime: How often does your pain effect these? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

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. Are there **ANY** other hereditary conditions the doctor should be aware of? ❑ No ❑Yes ~ _____

I hereby authorize payment to be made directly to PATH Wellness, 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 PATH Wellness for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date**

_____ _____ - _____ - _____
Doctor's Signature **Date**

Patient's Name: _____ **VRC#:** _____

PATH Wellness

Patient's Name: _____ **VRC#:** _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:				
Bending	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Concentrating	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Gardening	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Playing Sports	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Recreation Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Shoveling	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Sleeping	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Watching TV	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Carrying	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Dancing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Lifting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Pushing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Rolling Over	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Working	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Climbing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Doing Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Performing Sexual Activity	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Reading	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Running	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Sitting to Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	❑ N/A
Other: _____	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform	

Patient's Name: _____ **VRC#:** _____

SYMPTOMS

Please check the box for ALL of the following symptoms:

Headaches	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Migraines	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Jaw Pain/TMJ	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Shoulder Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Upper Back Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Mid-Back Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Low Back Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Hip Pain – R / L	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Scoliosis	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Numb/Tingling – Arms/Hands/Fingers	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Numb/Tingling – Legs/Feet/Toes	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Pregnant	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Frequent Colds / Flu	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Convulsions / Epilepsy	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Tremors	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Chest Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Pain w/ Coughing/Sneezing	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Sinus / Allergy Issues	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Foot / Knee Pain	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Swollen / Painful Joints	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Skin Problems	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Dizziness	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Loss of Balance	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Fainting	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Double Vision	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Blurred Vision	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Ringing in Ears	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Hearing Loss	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Depression	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Irritable / Mood Changes	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
ADD / ADHD	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Prostate Problems	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Impotence/Sexual Dysfunction	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A

Patient's Name: _____ **VRC#:** _____

SYMPTOMS (continued)

Please check the box for ALL of the following symptoms:

Digestive / Colon Issues	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Menstrual Issues / PMS / Menopause	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Learning Disabilities	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Eating Disorders	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Trouble Sleeping	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Ulcers	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Heartburn	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
High Blood Pressure	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Low Blood Pressure	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Asthma	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Difficulty Breathing	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Lung Issues	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Kidney Trouble	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Gall Bladder Trouble	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Liver Issues	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A
Hepatitis (A/B/C)	❑ PAST	❑ CURRENT	❑ NEVER	❑ N/A

List ANY Prescription & Non-Prescription drugs you are currently taking:

_____

_____

_____

Patient's Signature: _____ **Date:** _____ /_____ /_____

Doctor's Signature: _____ **Date:** _____ /_____ / _____