



Easton Pond Chiropractic, D. Gordon Gibson, DC

**Application for Care**

**Date:** \_\_\_\_\_

Name: First/Middle/Last \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please call me: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Where would you prefer to be contacted in order of preference?

\_\_\_\_ Home Phone    \_\_\_\_ Work Phone    \_\_\_\_ Cell phone    \_\_\_\_ Email

Would you like to receive our free email newsletter on health: YES NO

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Marital Status: S M D W Spouses Name: \_\_\_\_\_ # of Children \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employment Status: Full Part Retired Student – College/High School/Middle/Grade/Pre

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Reason for consulting our office:** \_\_\_\_\_

**\*\* Please check if you are here for any of the following:**

\_\_\_\_ Car Accident    \_\_\_\_ Work Injury    \_\_\_\_ Other injury

**The Beginning Years** – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

**Birth History** – Please check those items that apply to you

\_\_\_\_ Mother smoked/drank/drugs in pregnancy    \_\_\_\_ Epidural/Meds in labor    \_\_\_\_ Breech vaginal    \_\_\_\_ C-Section  
\_\_\_\_ Forceps Delivery    \_\_\_\_ Vacuum Extractor used    \_\_\_\_ Labor Induced    \_\_\_\_ Complications  
\_\_\_\_ Other \_\_\_\_\_

**Childhood Years (Age 0-17 yrs)** - Please check those items that apply to you

\_\_\_\_ Childhood Illness    \_\_\_\_ Serious Falls    \_\_\_\_ Active in Sports    \_\_\_\_ Very Inactive  
\_\_\_\_ Car Accident(s)    \_\_\_\_ Surgery/Stitches    \_\_\_\_ Alcohol/Drug Abuse    \_\_\_\_ Smoker  
\_\_\_\_ Antibiotics/Other Meds    \_\_\_\_ Vaccinated    \_\_\_\_ Under Chiropractic Care    \_\_\_\_ Broken Bones  
\_\_\_\_ Severe Emotional Trauma(s) \_\_\_\_\_

**Adult Years (Age 18 to present)** - Please check those items that apply to you

\_\_\_\_ Present Smoker    \_\_\_\_ Former Smoker    \_\_\_\_ Alcohol Use    \_\_\_\_ Play Sports  
\_\_\_\_ Car Accidents    \_\_\_\_ High Job Stress    \_\_\_\_ High Personal Stress    \_\_\_\_ Sit a lot  
\_\_\_\_ Drive a lot    \_\_\_\_ Poor Sleep    \_\_\_\_ Poor Diet    \_\_\_\_ No Exercise  
\_\_\_\_ Flat Feet    \_\_\_\_ Wear Orthotics/Lifts    \_\_\_\_ Hard Falls

\_\_\_\_ Other Injuries \_\_\_\_\_

\_\_\_\_ Severe Health Problems, Please List \_\_\_\_\_

\_\_\_\_ Surgeries, Please List \_\_\_\_\_

\_\_\_\_ Prescription Drugs, Please List \_\_\_\_\_

\_\_\_\_ Over the Counter Drugs, Please List \_\_\_\_\_

\_\_\_\_ Have been under chiropractic care in the past? - How long ago was your last adjustment? \_\_\_\_\_

\_\_\_\_ Who/Where was your previous chiropractor? \_\_\_\_\_

**For office use only:** \_\_\_\_\_ **OV** \_\_\_\_\_ **COPY** \_\_\_\_\_  
**Deductibles:** \_\_\_\_\_

**\*If you have no current health complaints and are interested in wellness care only, please skip to blue section. Otherwise, please complete the entire page.**

Chief Complaint(s): \_\_\_\_\_

How long have you had this problem currently? \_\_\_\_\_

Have you had this problem before? \_\_\_ Yes \_\_\_ No

Please explain, how often/How long: \_\_\_\_\_

How has this affected you? \_\_\_\_\_

If you have pain, is it: \_\_\_ Sharp \_\_\_ Dull \_\_\_ Constant \_\_\_ Intermittent \_\_\_ Traveling  
\_\_\_ Mild \_\_\_ Moderate \_\_\_ Moderately severe \_\_\_ Intolerable \_\_\_ Radiating

Since it began, is it: \_\_\_ About the same \_\_\_ Getting Better \_\_\_ Getting Worse \_\_\_ Variable

Did you have an injury? \_\_\_ Yes \_\_\_ No If Yes, Please explain: \_\_\_\_\_

Other doctors/treatments you've tried for this problem (Please list):

\_\_\_ Chiropractor \_\_\_\_\_

\_\_\_ Medical Doctor \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

Are there any other doctors you are currently under care with and why?

**Please check all recurring or current symptoms you have, even if they do not seem related to your current problem(s).**

- |                                 |                         |                                 |
|---------------------------------|-------------------------|---------------------------------|
| ___ Pins & Needles in arms      | ___ Headaches/Migraines | ___ Fatigue                     |
| ___ Pins & Needles in Legs/Feet | ___ Sinus Problems      | ___ Stomach upset               |
| ___ Numbness in Toes            | ___ Asthma              | ___ Heartburn/Reflux            |
| ___ Numbness in Fingers         | ___ Allergies           | ___ Diarrhea/Constipation/Gas   |
| ___ Back Stiffness/Pain         | ___ Dizziness/Vertigo   | ___ Ulcers                      |
| ___ Jaw/TMJ Problems            | ___ Nervousness/Anxiety | ___ Infertility/Impotence       |
| ___ Tension/Stress              | ___ Problems urinating  | ___ Menopause                   |
| ___ Buzzing/Ringing in Ears     | ___ Cold Feet           | ___ Pre-Menstrual Syndrome(PMS) |
| ___ Neck Stiffness/Pain         | ___ Cold Hands          | ___ Irritability/Mood Swings    |
| ___ Sleeping Problems           | ___ Foot Problems       | ___ Hot Flashes                 |
| ___ Loss of Balance             | ___ Cold Sweats         | ___ Depression                  |
| ___ Recurring Infection         | ___ Loss of Smell       | ___ High Blood Pressure         |
| ___ Light Bothers Eyes          | ___ Other _____         |                                 |

100% Sick  
(Dead)

Please use this line to rate your health right now

100% Healthy



I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge. I agree to allow this office to perform an assessment of me in order to make as complete an evaluation as possible.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

170 Aquidneck Avenue, Middletown RI 02842 – 401/848-7634