CORRECTIVE CHIROPRACTIC & WELLNESS

Patient Application Form

Welcome to our clinic!

Our purpose is to help you achieve your highest level of health by providing services that seek to restore and maintain your body to its optimum function. Our care is based on the scientific principles of anatomy and physiology and is focused on addressing causes of health problems instead of simply treating symptoms.

Our initial objective is to determine if you are in the right office. We must consider what issues you are having as well as what you are seeking. Please fill out the following information completely so the doctor has as much information as possible to determine if we can accept your case.

Please feel free to ask any questions if you need assistance.
We look forward to serving you!

_____
Patient's Name

_____
Patient's Signature

_____
Guardian Signature (if patient is under age 18)

_____
Date

CORRECTIVE CHIROPRACTIC & WELLNESS

PATIENT REGISTRATION

Title: Mr./Mrs./Ms./Dr./Rev./Rank_____ Date_____

Last Name_____ First Name_____ MI___ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Mobile Phone_____ Home Phone_____ Work Phone_____

E-Mail_____ SSN _____

Date of Birth_____ Age_____ Gender: M F Marital Status: S M W D

Employer Name_____ Occupation_____

Spouse Name_____ Phone_____ Spouse Employer/Occupation_____

Children (names, ages) _____

Most of our patients are referred by a family member or friend, what made you decide to visit our office?

□ Friend or Family Member Name_____

□ Website □ Internet search □ Facebook □ Sign/Drive-by □ Newspaper □ Yellow Pages

□ Presentation _____ □ Spinal Screening _____ □ Other_____

Have you, your spouse or children ever received chiropractic care? _____

Primary Doctor _____

CURRENT HEALTH COMPLAINT

Reason for this visit:_____

Is this related to an auto accident or work injury? Yes No If yes, when_____

Approximately, when did this condition begin?_____ Did it begin: Gradually Suddenly

What makes your symptoms worse?_____

What makes your symptoms better?_____

Symptom characteristics: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

Does it radiate into your arms or legs? Yes No Is the condition getting worse? Yes No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does your complaint interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine

Explain:_____

Have you experienced this condition before? Yes No If yes, please explain _____

Have you been evaluated/treated for this? Yes No If yes, by whom?_____

What did they do? _____

How did you respond? _____

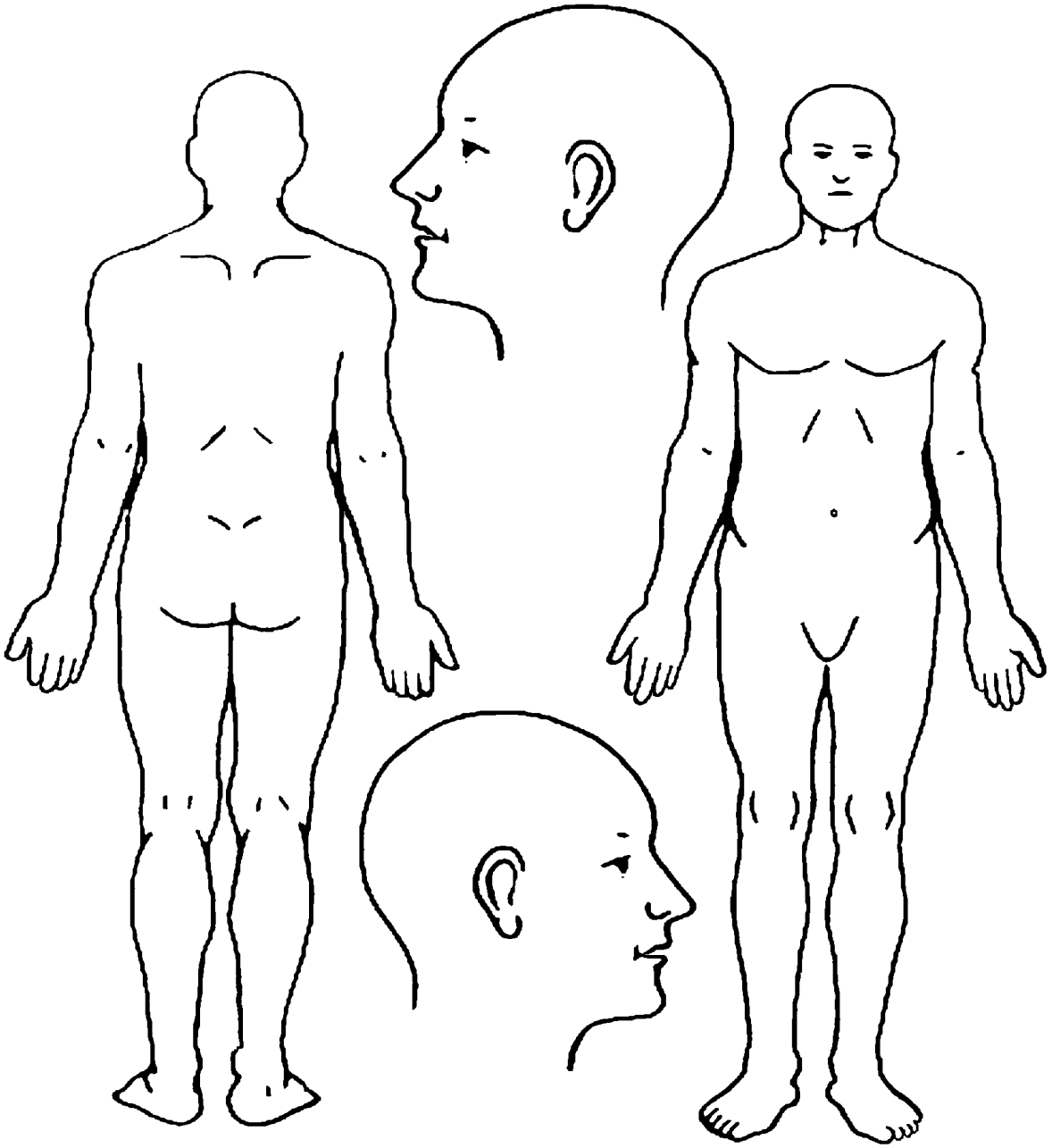
NAME:_____DATE_____

BORG PAIN SCALE

On a scale of 1-10, please rate your pain level.

Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Please place "X's" where you feel your pain.



Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

HEALTH CONDITIONS

A **subluxation** is when spinal dysfunction puts stress on your spinal cord and the delicate nerves that pass between each of the vertebrae. This dysfunction can be caused by things like trauma or chronic poor posture. Please mark any health condition you may be experiencing.

CERVICAL SPINE (NECK)

Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and head and can cause the following problems; do you have any of these?

___Neck pain
___Headaches
___Thyroid condition
___Sinusitis
___Allergies
___Depression
___Pain into your shoulders/arms/hands
___Numbness/tingling in arms/hands
___Ears ringing/loss of hearing
___Weakness in grip
___Visual disturbances
___Loss of balance
___Cold hands
___High blood pressure
___Recurrent colds/flu
___Low energy/fatigue
___TMJ pain/clicking
___Sleeping problems

THORACIC SPINE (UPPER AND MID BACK)

Subluxations in your upper and mid back weaken the nerves that go to your lungs, heart, ribs/chest, and upper digestive tract; do you have any of these?

___Heart palpitations
___Diabetes
___Tachycardia
___Mid back pain
___Rib/chest pain
___Heart attacks/angina
___Asthma/wheezing
___Shortness of breath
___High Cholesterol
___Nausea
___Recurrent lung infections/bronchitis
___Pain on deep inspiration/expiration
___Hypoglycemia
___Stomach Upset
___Ulcers/Gastritis

LUMBAR SPINE (LOW BACK)

Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet; do you have any of these?

___Pain in your hips/legs/feet
___Muscle cramps in your legs/feet
___Constipation/diarrhea
___Coldness in your legs/feet
___Weakness in your hips/knees/ankles
___Menstrual irregularities/cramping
___Numbness/tingling in your legs/feet
___Frequent/difficulty urinating
___Low back pain
___Sexual dysfunction

Please list any health conditions not mentioned:_____

Are you pregnant? Yes No If so, how many weeks? _____

HEALTH HISTORY

Current medications (including for what symptom and any side effects you have experienced):

_____

_____

_____

Please list all past surgeries, major illnesses or diseases, hospitalizations (with approximate date):

_____

_____

Please list any previous accidents and injuries:

_____ _____

_____

Family History

Mother's Side	Heart Disease	Stroke	Arthritis	Cancer	Diabetes	Other_____
Father's Side	Heart Disease	Stroke	Arthritis	Cancer	Diabetes	Other_____

LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X 6X 7X per week

What activities? Running Walking Weights Cycling Yoga Swimming Other_____

Do you smoke? Yes No How many packs per day?_____ Any desire to quit? Yes No

Do you drink alcohol? Yes No What and how much?_____

Do you drink coffee? Yes No How many cups per day?_____

Do you drink soda? Yes No How many per 12 oz. servings per day?_____

Do you drink water? Yes No How much per day?_____

Do you eat vegetables and fruits? Yes No How many servings per day?_____

How often do you eat processed foods? Never Rarely Occasionally Often Exclusively

Do you take any supplements (i.e. vitamins, minerals, herbs)?_____

What is your average stress level (including work, school, family…)? Very Low Low Moderate High Very High

How many hours do you sleep each night? _____

****

As a result of my chiropractic care I would like (check all that apply)

___Symptom relief ___A healthier spine and nervous system ___Spine and body alignment

___Injury prevention ___Improved balance and coordination ___Wellness and health education

___Increased range of motion, flexibility and mobility

****

I attest that all of the above health and lifestyle information is correct to the best of my knowledge. I also understand the Additional Privacy Practices listed below.

ADDITIONAL PRIVACY PRACTICES

- We may call you by name in the reception area when the doctor is ready to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

_____ _____

Patient/Guardian Signature Date

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care, and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective: to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- Health/Automobile Insurance
    - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we cannot take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
    - In-Network Policies: We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement. Co-pays will be paid by patient, reimbursement checks will be payable to us.
    - Out-of-Network Policies: We will give you receipts to file with your insurance company. Patient will pay cash prices up front. Insurance company will reimburse the patient.
    - If your policy has a deductible feature, it is due at the time of service.
    - In accordance with Medicare Guidelines, Maintenance Care is not a covered benefit and therefore will not be billed to your insurance company.
    - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a $25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURING

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED

- *Over-the-counter analgesics*. Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care*, typically anti-inflammatory drugs, injections, and analgesics. Temporarily relieve pain but do not address the cause of the symptoms. Masking the pain means you may not feel additional damage. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

PATIENT SIGNATURE (or Parent/Guardian) DATE

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period _____ Initials_____

Corrective Chiropractic and Wellness

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Corrective Chiropractic and Wellness.

I understand that the Notice describes the uses and disclosures of my protected health information by Corrective Chiropractic and Wellness and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*