Patient Application

Please complete the application in full and use N/A for anything that does not apply.

Please Print in BLUE or BLACK ink

Full Legal Name _____ Age _____ DOB _____ / _____ / _____
First **Middle** **Last**

Home Address _____ City _____ State _____ Zip Code _____

Cell Phone ( ) _____ Home Phone ( ) _____

E-Mail Address _____

Marital Status S M D W Name of Spouse _____

Names and Ages of Children _____

_____

Occupation _____ Employer _____

Business Address _____ City _____ State ____ Zip _____

Business Phone ( ) _____ May we contact you at work? Yes No

Person to contact in case of emergency _____ Ph # ( ) _____ Relationship _____

How were you or who referred you to our clinic? _____

What are your main concerns to see the doctor today? _____

_____

Have you ever received Chiropractic care? Yes No Chiropractor's name _____

Date of last adjustment _____ / _____ / _____ Reason for ending care _____

Name of current medical doctor _____ Phone ( ) _____

Date of last medical examination _____ / _____ / _____

Which of the Following Most Clearly Describes Your Current Goals for Health

_____ I am concerned with pain relief **only.**

_____ I am concerned with pain relief ***AND*** learning how to improve my health to prevent future health concerns.
(May include fitness, dietary, sleeping and positive affirmation habit modification)

Physical, Emotional and Chemical Stress History

Name_____

Five most recent accidents: Slips, Falls, Car Crashes etc.

1 _____ Year _____

2 _____ Year _____

3 _____ Year _____

4 _____ Year _____

5 _____ Year _____

Percentage of time you sleep in the following positions Stomach _____ Right Side _____ Left Side _____ Back_____

Total sleep hours per night _____ Peaceful Restless ***Do you wear custom fit orthotics*** Yes No

List sports played as a child _____

List any broken bones _____

Stress level **Scale 0 - 10 (10 WORST)** 0 1 2 3 4 5 6 7 8 9 10

Energy level **Scale 0 - 10 (10 BEST)** 0 1 2 3 4 5 6 7 8 9 10

Dietary habits (Circle)

Coffee Soda Diet Soda Alcohol Sweets Artificial Sweeteners Sugarless Gum GMO foods

Smoking Tobacco Smokeless Tobacco Organic foods Non-Organic meats Organic meats Dairy

List disease history _____

List surgery history _____

List current exercise habits _____

List your TOP 3 Goals regarding your health _____

_____

Current "Prescription" Meds	**Current "Over-the-Counter" Meds**	**Current Nutritional Supplements**

Health History Questionnaire

INSTRUCTIONS:

Please circle the most appropriate answer.

Patient Name _____

Date ____ / ____ / _____ Score _____

A

1	Do you need glasses to read?	YES	NO
2	Do you need glasses to see things at a distance?	YES	NO
3	Has your eyesight often blacked out completely?	YES	NO
4	Do your eyes continually blink or water?	YES	NO
5	Do you often have bad pains in your eyes?	YES	NO
6	Are your eyes often red or inflamed?	YES	NO
7	Are you hard of hearing?	YES	NO
8	Have you ever had a draining ear?	YES	NO
9	Do you have constant noises in your ears?	YES	NO

B

10	Do you have to clear your throat frequently?	YES	NO
11	Do you often feel a choking lump in your throat?	YES	NO
12	Are you often troubled with bad spells of sneezing?	YES	NO
13	Is your nose continually stuffed up?	YES	NO
14	Do you suffer from a constantly running nose?	YES	NO
15	Have you at times had bad nose bleeds?	YES	NO
16	Do you often catch severe colds?	YES	NO
17	Do you frequently suffer from heavy chest colds?	YES	NO
18	Do you frequently go to bed when you have a cold?	YES	NO
19	Do frequent colds keep you miserable during the year?	YES	NO
20	Do you get hay fever?	YES	NO
21	Do you suffer from asthma?	YES	NO
22	Are you troubled by constant coughing?	YES	NO
23	Do you frequently cough up blood?	YES	NO
24	Do you sometimes have severe soaking sweats at night?	YES	NO
25	Have you ever had a chronic chest condition?	YES	NO
26	Have you ever had T.B. (Tuberculosis)?	YES	NO
27	Did you ever live with anyone who had T.B.?	YES	NO

C

28	Has a doctor ever said your blood pressure was too high?	YES	NO
29	Has a doctor ever said your blood pressure was too low?	YES	NO
30	Do you have pains in the heart or chest?	YES	NO
31	Are you often bothered by thumping of the heart?	YES	NO
32	Do you often have a rapid heart rate?	YES	NO
33	Do you often have difficulty in breathing?	YES	NO
34	Do you get out of breath easily?	YES	NO
35	Do you sometimes get out of breath just sitting still?	YES	NO
36	Are your ankles often swollen?	YES	NO
37	Do cold hands or feet trouble you even in hot weather?	YES	NO
38	Do you suffer from frequent cramps in your legs?	YES	NO
39	Has a doctor ever said you had heart trouble?	YES	NO
40	Does heart trouble run in your family?	YES	NO

D

41	Have you lost more than half your teeth?	YES	NO
42	Are you troubled by bleeding gums?	YES	NO
43	Have you often had severe toothaches?	YES	NO
44	Is your tongue usually badly coated?	YES	NO
45	Do you frequently have a poor appetite?	YES	NO
46	Do you usually eat sweets or other food between meals?	YES	NO
47	Do you gulp your food in a hurry'?	YES	NO
48	Do you often suffer from an upset stomach?	YES	NO
49	Do you usually feel bloated after eating?	YES	NO
50	Do you usually belch a lot after eating?	YES	NO
51	Are you often sick to your stomach?	YES	NO
52	Do you suffer from indigestion?	YES	NO
53	Do severe pains in the stomach often double you up?	YES	NO
54	Do you suffer from constant stomach trouble?	YES	NO
55	Does stomach trouble run in your family?	YES	NO
56	Has a doctor ever said you had stomach ulcers?	YES	NO
57	Do you suffer from frequently loose bowel movements?	YES	NO
58	Have you ever had bloody diarrhea?	YES	NO
59	Were you ever troubled with intestinal parasites?	YES	NO
60	Do you frequently suffer from constipation?	YES	NO
61	Have you ever had hemorrhoids?	YES	NO
62	Have you ever had jaundice (yellow eyes and skin)?	YES	NO
63	Have you ever had serious liver or gall bladder trouble?	YES	NO

E

64	Are your joints often painfully swollen?	YES	NO
65	Do your muscles and joints frequently feel stiff?	YES	NO
66	Do you usually have severe pains in the arms or legs?	YES	NO
67	Are you debilitated with severe arthritis?	YES	NO
68	Does arthritis run in your family?	YES	NO
69	Do weak or painful feet make your life miserable?	YES	NO
70	Does back pain make it difficult to get through your day?	YES	NO
71	Are you troubled with a serious disability or deformity?	YES	NO

F

72	Is your skin very sensitive or tender?	YES	NO
73	Do cuts and bruises heal slowly?	YES	NO
74	Does your face often get badly flushed?	YES	NO
75	Do you sweat a great deal even in cold weather?	YES	NO
76	Are you often bothered by severe itching?	YES	NO
77	Does your skin often break out in a rash?	YES	NO
78	Are you often troubled with acne or boils?	YES	NO

Name_____

G

79	Do you suffer from frequent headaches?	YES	NO
80	Does pressure in the head often make life miserable?	YES	NO
81	Are headaches common in your family?	YES	NO
82	Do you have hot or cold spells?	YES	NO
83	Do you often have spells of dizziness?	YES	NO
84	Do you frequently feel faint?	YES	NO
85	Have you fainted more than twice in your life?	YES	NO
86	Do you have numbness or tingling in any body part?	YES	NO
87	Was any part of your body ever paralyzed?	YES	NO
88	Were you ever knocked unconscious?	YES	NO
89	Have you at times had a twitching of the face or head?	YES	NO
90	Did you ever have convulsions or seizures?	YES	NO
91	Has anyone in your family had convulsions or seizures?	YES	NO
92	Did you ever bite your nails badly?	YES	NO
93	Have you ever been troubled by stuttering or stammering?	YES	NO
94	Are you a sleep walker?	YES	NO
95	Are you currently a bed wetter?	YES	NO
96	Were you a bed wetter as a child?	YES	NO

H – FEMALE ONLY

97	Were or are your menstrual periods usually painful?	YES	NO
98	Have you often felt weak or sick with your periods?	YES	NO
99	Have you often had to lie down during your period?	YES	NO
100	Are you usually tense or jumpy with your periods?	YES	NO
101	Do you have frequent hot flashes and sweats?	YES	NO
102	Have you often been troubled with vaginal discharge?	YES	NO
103	Do you frequently get up at night to urinate?	YES	NO
104	During the day, do you have to urinate frequently?	YES	NO
105	Do you often have burning pain when you urinate?	YES	NO
106	Do you sometimes lose control of your bladder?	YES	NO
107	Have you ever had kidney or bladder disease?	YES	NO

H – MALE ONLY

108	Have you ever had a health problem with your genitals?	YES	NO
109	Are your genitals often painful or swollen?	YES	NO
110	Have you ever had treatment for your genitals?	YES	NO
111	Have you ever had an inguinal hernia?	YES	NO
112	Have you ever passed blood while urinating?	YES	NO
113	Do you have difficult or slow urination?	YES	NO
114	Do you frequently get up at night to urinate?	YES	NO
115	During the day, do you urinate frequently?	YES	NO
116	Do you often have burning while urinating?	YES	NO
117	Do you sometimes lose control of your bladder?	YES	NO
118	Have you ever had kidney or bladder disease?	YES	NO

I

119	Do you often feel completely exhausted or fatigued?	YES	NO
120	Does working tire you out completely?	YES	NO
121	Do you usually wake up tired and exhausted?	YES	NO
122	Does every little effort wear you out?	YES	NO
123	Are you frequently too tired and exhausted to eat?	YES	NO
124	Do you suffer from frequent nervous exhaustion?	YES	NO
125	Does nervous exhaustion run in your family?	YES	NO

J

126	Are you frequently ill?	YES	NO
127	Are you frequently confined to bed by illness?	YES	NO
128	Are you frequently in poor health?	YES	NO
129	Are you considered a sickly person?	YES	NO
130	Do you come from a sickly family?	YES	NO
131	Do aches and pains make it difficult to work?	YES	NO
132	Do you wear yourself out worrying about your health?	YES	NO
133	Are you frequently depressed and unhappy?	YES	NO
134	Do you feel over whelmed due to poor health?	YES	NO

K

135	Did you ever have scarlet fever?	YES	NO
136	Have you had rheumatic fever?	YES	NO
137	Did you ever have malaria?	YES	NO
138	Were you ever treated for anemia?	YES	NO
139	Have you been treated for a sexually transmitted disease?	YES	NO
140	Do you have diabetes?	YES	NO
141	Did a doctor ever say you had a goiter?	YES	NO
142	Have you ever been treated for a tumor or cancer?	YES	NO
143	Did you suffer from any chronic disease?	YES	NO
144	Are you definitely under weight?	YES	NO
145	Are you definitely over weight?	YES	NO
146	Do you have varicose veins in your legs?	YES	NO
147	Have you ever had surgery?	YES	NO
148	Did you ever have a serious injury?	YES	NO
149	Do you often have small accidents or injuries?	YES	NO

L

150	Do you have difficulty falling asleep or staying asleep?	YES	NO
151	Do you find it impossible to take a rest break daily?	YES	NO
152	Do you find it impossible to exercise daily?	YES	NO
153	Have you ever or do you smoke tobacco? Packs/day? _____	YES	NO
154	Do you frequently drink coffee or tea?	YES	NO
155	Do you frequently drink alcohol?	YES	NO

Name_____

Health Insurance Portability and Accountability Act (HIPAA)

AUTHORIZATION FOR USE OF HEALTH CARE INFORMATION:

In the course of your care we may use in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider for further diagnosis.

Under Federal Law, we are also permitted and required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency situation.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care for you.
- If we are ordered by the courts or another appropriate agency.

You have the right to inspect and/or copy your health information for a period of seven years. You have a right to amend the information in your file provided a request is submitted in writing.

AUTHORIZATION FOR CONTACT REGARDING CHIROPRACTIC CARE RELATED TO HEALTH SERVICES AND/OR HEALTH PRODUCT:

It is our desire to use your name, address and email or telephone number for the purpose of contacting you to advise you about future appointments, workshops, and products.

PATIENT AUTHORIZATION FOR REFERRALS AND TESTIMONIALS:

It is our desire to post your name in appreciation for referring patients to our office. If you respond favorably to chiropractic care, you may be asked to fill out a "patient testimonial," you may decline if you wish. This will help others read the success of chiropractic. Your referrals and testimonials help spread the word of chiropractic to others who may not be unaware that they could be helped.

The use of this information mentioned in the above three sections is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from our office or on your relationship with us.

OPEN ADJUSTMENT ENVIRONMENT:

Our office is an open adjusting environment. Your consultations, examinations, scans, x-rays, and report of findings are preformed in private.. Conversations between you, your doctor, and anyone else during normal treatments may be overheard by others. Our goal is to maintain as much privacy as possible. If you are uncomfortable discussing your case, you may request a private consultation for your next visit.

Your signature indicates you have read, understood, and authorize the above activities.

_____ _____ ***Date*** ____ / _____ / _____

Printed Name of Patient ***Patient Signature***

If patient is under the age of 18, signature of your Parent or Guardian _____ ***Date*** ____ / _____ / _____

Signature of Parent or Guardian

****This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of you desire to withdraw your authorization. Please allow a reasonable amount of time for the change in our system to be completed.***

Name_____

Financial Information

Payment in full is required on each visit unless prior arrangements have been made.

Please indicate your preferred method of payment. _____ Cash _____ Check

When a patient seeks chiropractic health care and we accept a patient for care, it is essential for both to be working toward the same objective. **Our practice objective is to eliminate Subluxations that create interference within your nervous system.** Your prescribed care plan is designed with this in mind. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment. If during the course of chiropractic examination we recognize non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

INFORMATION CONSENT TO RECEIVE CHIROPRACTIC CARE:

I, the undersigned, give the doctor permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis and treatment. Chiropractic care seldom causes any complications, but in rare cases, due to underlying physical defects, deformities or pathologies may render a patient susceptible to injury. The doctor will not provide care if they are aware of any contraindication that may be present. It is the responsibility of the patient to make it known to the doctor or health care provider if they are aware of any underlying deformities or defects that may not otherwise come to the attention of the doctor.

_____ Date___ / ___ / _____
Signature of Patient

If patient is under the age of 18, signature of your Parent or Guardian _____ Date ___ / ____ / _____
Signature of Parent or Guardian

Thank you for choosing us!

We look forward to helping you develop optimum health, vitality and wellness!