

Patient Application



Welcome to our clinic! We strive to assist our patients in achieving the highest level of health through our spinal and postural corrective programs. Our approach is very unique compared to other rehabilitative programs.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance. We look forward to serving you!

Patient Signature

Date

PATIENT INFORMATION

Patient Last Name _____ First Name, MI _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____
Social Security # _____ DL# _____
Birthdate _____ Age _____ M/F _____ Marital Status _____
Employer _____ Occupation _____
Work Address _____ Work Phone _____
How were you referred to this office? _____ Native Language _____
of Children _____ Names (Ages) of children _____
Do you notice poor postural habits in your children? Yes /No _____
Explain _____
Spouse's Name _____ Spouse's Age _____
Spouse's Employer _____ Spouse's Work Phone _____
Spouse's Occupation _____ Spouse's Cell Phone _____

INSURANCE INFORMATION

COMMERCIAL INSURANCE AND MEDICARE ONLY

Primary Insurance Company Name _____ Type (Group/Private) _____
Membership/Cert # _____ Policy/Group # _____
Insured's Name _____ Insured's Relationship to Patient _____
Insured's Birthdate _____ Insured's Social Security # _____
Secondary Insurance Company Name _____ Type (Group/Private) _____
Membership/Cert # _____ Policy/Group # _____
Insured's Name _____ Insured's Relationship to Patient _____
Insured's Birthdate _____ Insured's Social Security # _____

AUTOMOBILE ACCIDENT/WORKER'S COMPENSATION ONLY

Insurance Company Name _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Claim # _____ Policy # _____ Adjuster's Name _____
Attorney's Name _____ Contact Name _____ Phone # _____
Address _____ City _____ State _____ Zip _____

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I authorize any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ Date _____
Guardian or Spouse's Signature Authorizing Care _____ Date _____

PURPOSE OF THIS VISIT

Reason for this visit _____ Auto accident/work injury? Yes/No _____
When did this condition begin/when did you first notice it? _____
What activities aggravate your symptoms? _____
Does anything relieve your symptoms? Yes/No _____ Describe _____
Have you experienced this condition before? Yes/No _____ Who have you seen for this? _____
What did they do? _____ How did you respond? _____

HEALTH CONDITIONS

Please check any health conditions you may be experiencing now or have experienced in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing from Forward Head Syndrome), in your neck will weaken the nerves in your arms, hands and head and affect these parts of your body. Do you experience...?

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Jaw Pain/Jaw Clicking (TMJ) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing disturbances/loss |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Immune Disorders (AIDS/HIV) |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blurred/Double Vision | <input type="checkbox"/> Immune Disorders (RA/Lupus) |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Coldness in hands | |
| <input type="checkbox"/> Recurrent Colds/Flus | <input type="checkbox"/> Pain in shoulders/arms/hands | <input type="checkbox"/> Thyroid conditions | |
| <input type="checkbox"/> Low Energy/Fatigue | | <input type="checkbox"/> Numbness/tingling in arms/hands/fingers | |

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations, (resulting from Forward Head Syndrome), in the upper back will weaken the nerves to the heart and lungs and affect these parts of the body. Do you experience...?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recurrent lung infections/bronchitis | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Heart attacks/Angina of breath | <input type="checkbox"/> Upper back pain, stiffness | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Curvature of Spine/Scoliosis |
| <input type="checkbox"/> Pain on deep inspiration/expiration | <input type="checkbox"/> Chest pain, asthma | <input type="checkbox"/> Shortness of breath | |
| | <input type="checkbox"/> Heart problems/Stroke | <input type="checkbox"/> Heart murmurs | |
| | <input type="checkbox"/> High/low blood pressure | | |

THORACIC SPINE (MID BACK):

Postural distortions from subluxations, (resulting from Forward Head Syndrome), in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- | | | |
|--|---|--|
| <input type="checkbox"/> Mid back pain/stiffness | <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/irritable after eating or when hungry |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Nausea | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Gall bladder trouble |
| | <input type="checkbox"/> Hypoglycemia | |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations, (resulting from Forward Head Syndrome), will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping/PMS (females) | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Numbness/tingling in your buttocks/legs/feet/toes | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Recurrent bladder infections | <input type="checkbox"/> Low back pain/ stiffness | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | <input type="checkbox"/> Hemorrhoids | Other Conditions: |
| | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Cancer |
| | | | <input type="checkbox"/> Convulsions/Epilepsy |
| | | | <input type="checkbox"/> Fractured Bones |

Please list any health conditions you have that were not mentioned _____

Please list any medications/surgeries _____

ACCIDENT DETAILS

- When was your most recent auto accident? _____ Speed _____ Front/Side Collision Rear-end
Was treatment received? Yes No If yes, where? _____
- When was your most recent stress or strain at work? _____ Was any treatment needed? Yes No
- What sport or recreational activities do you do? _____
When was your most recent activity related stress or strain? _____ Was any treatment received? Yes No
- Is there any other injury to your spine, minor or major, that the doctor should know about? _____

HEALTH LIFESTYLE

Do you exercise? _____ How often? _____
What activities _____
Do you smoke? _____ How much? _____
Do you drink alcohol? _____ How much/week? _____
Do you drink coffee? _____ How many cups/day? _____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____
Do you have difficulty with any of the following now or in the past? (Circle any that apply) Sleeping, Concentrating, Depression, Mood changes, Irritability, Tremors, Skin conditions, Eating disorders, Learning disabilities, Fainting, Anemia
What are your health goals? _____
How do you expect to achieve these goals? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Chiropractor's Name _____
Reason(s) for Visits _____
What spinal maintenance programs were you given to follow to maximize the future stability of your spine?

Did you follow it? Yes No If not why? _____
How did you respond? _____
Are you currently wearing: Heel lifts _____ Arch Supports _____ Back Brace _____
Did you know your posture determines your health? Yes No
Are you aware of poor postural habits? Self Spouse Children
Explain _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or feel like you carry your head forward? Yes No

IN CASE OF EMERGENCY CALL:

Name _____
Relationship _____
Work Phone _____
Home Phone _____
Cell Phone _____

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

Patient's Signature

Date

Parent/Guardian

Date