PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in empowering people to live a more active and healthy lifestyle. Our approach is very unique and advanced, combining structural corrective chiropractic treatment with manual and movement physical therapies.

Please fill out the following information thoroughly so we can assess whether you are an appropriate candidate for care in our office. This serves as one of our tools to help you achieve optimal success. Please feel free to ask any questions if you need assistance. We look forward to serving you.

PATIENT APPLICATION SURVEY

Name: ____ (Age) ______ Gender: M F

Home Address: ____ Home Phone: ( ) ______________________

City, State, Zip: ____ Work Phone: ( ) ______________________

Email Address: ____ Cell Phone: ( ) ______________________

Birth Date: _____ / _____ / ______ Social Security #: _______ - _____ - ________ Marital Status: S M D W

Occupation: ____ Employer Name: ___________________________

Spouse's Name: _______________________ Work Phone: ( ) __________________ Cell Phone: ( ) _________________

Spouse's Employer: ____________________________________ Occupation: ______________________________________

Names of Children: ____ Ages: __________________

How were you referred to this office? ____

PURPOSE OF THIS VISIT

Reason for this visit: ____

Is this condition related to: ☐ Auto Accident ☐ Work Injury If so, date of injury: _______________________________________

Please describe the pain & its location: ____

When did this condition begin? _________/_____/________ When did you first notice it? _________________________________

Please circle your worst pain level in the past couple of days: (Mild) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Severe)

Is this condition getting worse? ☐ Yes ☐ No Is this condition: ☐ Constant ☐ Comes & goes ☐ Activity related

What aggravates your symptoms? ☐ Driving ☐ Reaching ☐ Lifting ☐ Reading ☐ Stairs ☐ Walking ☐ Sitting ☐ Standing ☐ Prolonged Positioning

Prior level of function: ☐ Normal/No complaints ☐ Limits __________________________________

Does complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain: ________________________________

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: ____

Whom have you seen for this? ___________________________________ What did they do? ______________________________

How did you respond? ____

Please list any surgeries / current medications: ____

Please list any other health conditions you have: ____

EXPERIENCE WITH CHIROPRACTIC • PT • ACUPUNCTURE

Have you seen a **Chiropractor** before? ☐ Yes ☐ No Who? _____________________________ When? __________________

Reason for visits: ____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Have you seen a **Physical Therapist** before? ☐ Yes ☐ No Who? ___________________________ When? __________________

Reason for visits: ____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Have you seen an **Acupuncturist** before? ☐ Yes ☐ No Who? _____________________________ When? __________________

Reason for visits: ____ How did you respond? ☐ Better ☐ Worse ☐ No Change

Are you aware of any of your poor posture habits? ☐ Yes ☐ No Explain: ____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No 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 felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? ☐ Yes ☐ No

HEALTH LIFESTYLE

Do you exercise? □ Yes □ No How often? 1X 2X 3X 4X 5X per week Other: ____

What activities? □ Running □ Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming Other: _________________

Do you smoke? □ Yes □ No How much? ____

Do you drink alcohol? □ Yes □ No How much / week? ____

Do you drink coffee? □ Yes □ No How many cups / day? ____

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

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. It has been extensively documented that these misalignments, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted posture. Postural distortions have many serious and adverse affects on your overall health.

Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):
Postural distortions in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

□ Neck Pain □ Headaches □ Sinusitis

□ Pain into your Shoulders/Arms/Hands □ Dizziness □ Allergies/Hay Fever

□ Numbness/Tingling in Arms/Hands □ Visual Disturbances □ Recurrent Colds/Flu

□ Hearing Disturbances □ Coldness in Hands □ Low Energy/Fatigue

□ Weakness in Grip □ Thyroid Conditions □ TMJ/Pain/Clicking

Explain: ____

THORACIC SPINE (UPPER BACK):
Postural distortions in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

□ Heart Palpitations □ Recurrent Lung Infections/Bronchitis □ Heart Murmurs Asthma/Wheezing

□ Tachycardia □ Shortness of Breath □ Pain on Deep Inspiration/Expiration □ Heart Attacks/Angina

Explain: ____

THOPRACIC SPINE (MID BACK):
Postural distortions 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…?

□ Mid Back Pain □ Nausea □ Pain into your Ribs/Chest □ Ulcers/Gastritis □ Indigestion/Heartburn

□ Hypoglycemia □ Reflux □ Tired/Irritable after eating or when you haven't eaten for a while

Explain: ____

LUMBAR SPINE (LOW BACK):
Postural distortions in the low back and pelvis will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

□ Pain into Your Hips/Legs/Feet Weakness/Injuries in Your Hips/Knees/Ankles □ Low Back Pain

□ Numbness/Tingling In Your Legs/Feet □ Recurrent Bladder Infections

□ Coldness in Your Legs/Feet □ Frequent/Difficulty Urinating

□ Muscle Cramps in Your Legs/Feet □ Menstrual Irregularities/Cramping (females)

□ Constipation / Diarrhea □ Sexual Dysfunction

Explain: ____

FAMILY HEALTH HISTORY

Have you or any of your family members ever been diagnosed with the following:

☐ Diabetes	☐ Varicose Veins	☐ Neurological Problems	☐ Lung Disease
☐ Rheumatic Fever	☐ Circulatory Problems	☐ Stroke	☐ Heart Murmur
☐ High Blood Pressure	☐ Heart Disease	☐ Cancer	☐ Osteoporosis
☐ Kidney Disease	☐ Epilepsy/Seizures	☐ Migraine Headaches	☐ Arthritis
☐ Liver Disease	☐ Metal Implants	☐ Infectious Disease	☐ Gall Bladder
☐ Appendectomy	☐ Tonsillectomy	☐ Hernia	☐ Broken Bones/Fractures
☐ Pneumonia	☐ Polio	☐ Tuberculosis	☐ Anemia
☐ Whooping Cough	☐ Chicken Pox	☐ Mumps	☐ Measles
☐ Thyroid	☐ Small Pox	☐ Influenza	☐ Pleurisy
☐ Arthritis	☐ Lumbago	☐ Eczema	

☐ Other: ____

CARE AUTHORIZATION

I authorize and agree to allow the doctor, physical therapist and/or acupuncturist to work with my spine and/or extremities through the use of spinal adjustments, manual therapies, modalities and rehabilitative exercises for the purpose of 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, physical therapist and/or acupuncturist 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 or extremity conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's, physical therapist's and/or acupuncturist'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 to be directed to the doctor, physical therapist and/or acupuncturist for services rendered.

______________________ ____ ____________________

Patient's Name (Printed) Patient's Signature Date

I hereby authorize Advanced Spine & Wellness Center to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

____ ____________________

Parent/Guardian's Signature Authorizing Care for Minor Date

EMERGENCY CONTACT

Name ____

Relationship ___________________________________

Home Phone ___________________________________

Work Phone ___________________________________

Cell Phone ____________________________________

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Advanced Spine & Wellness Center 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 responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Advanced Spine & Wellness Center immediately to notify them of the nonpayment/rejection notice.

Patient's Signature____ Date______________________

Parent/Guardian's Signature ____________________________________ Date______________________

Who should receive charges on your account?

☐ Health Insurance ☐ Medicare ☐ Auto Insurance ☐ Workers' Compensation

☐ Patient ☐ Spouse ☐ Parent/Guardian

Name of Insurance Co. ____ Policy #____________________

Insured's Name_____________________________________ Insured's SS # __________________________

Insured's Relationship to Patient __________________________ Insured's Birth Date ______/______/______

Do you have a secondary or supplemental insurance policy? ☐ Yes ☐ No

Secondary Insurance Co. _______________________________________ Policy #____________________

If auto accident or work injury:

Claim #____ Date of Injury _____/_____/_____

Adjuster____ Phone # ____________________

Attorney____ Phone # ____________________

RADIOGRAPH CONSENT

I hereby give my consent to allow Advanced Spine & Wellness Center and its representatives, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant. _______ (Initial)

Signature of Patient or Guardian ____ Date ___________

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES ADVANCED SPINE & WELLNESS CENTER TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Advanced Spine & Wellness Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or other media.

I authorize Advanced Spine & Wellness Center to send me records electronically. ☐ YES ☐ NO

I consent to be added to Advanced Spine & Wellness Center's email list. ☐ YES ☐ NO

I give permission to Advanced Spine & Wellness Center to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health care information during the course of my treatment. Should I need to speak with a doctor, physical therapist or acupuncturist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Advanced Spine & Wellness Center permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health care information for directory purpose
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Signature of Patient or Guardian ____ Date ____________