APPLICATION FOR CHIROPRACTIC CARE

PATIENT INFORMATION

Patient Name _____ (LAST NAME)

_____ (FIRST NAME) (MIDDLE INITIAL)

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ Birthday _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Significant Other

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

Insurance Policy _____

Insured Name _____

Insured D.O.B. _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle) NO SYMPTOMS (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) INTENSE SYMPTOMS

When did this condition begin? _____

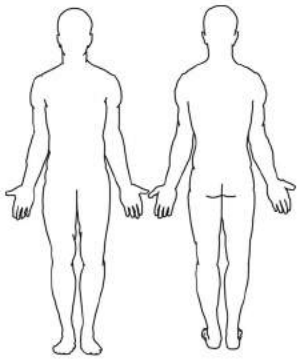
Has it occured before? ☐ Yes ☐ No

What does it feel like? (check where appropriate)

☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing
☐ Cramping ☐ Swelling
☐ Nagging ☐ Other _____

How did it start? _____

Please circle areas below where you have pain or other symptoms:



How often is the complaint/pain present? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional ☐ Infrequent

What solutions have you attempted to solve this problem? _____

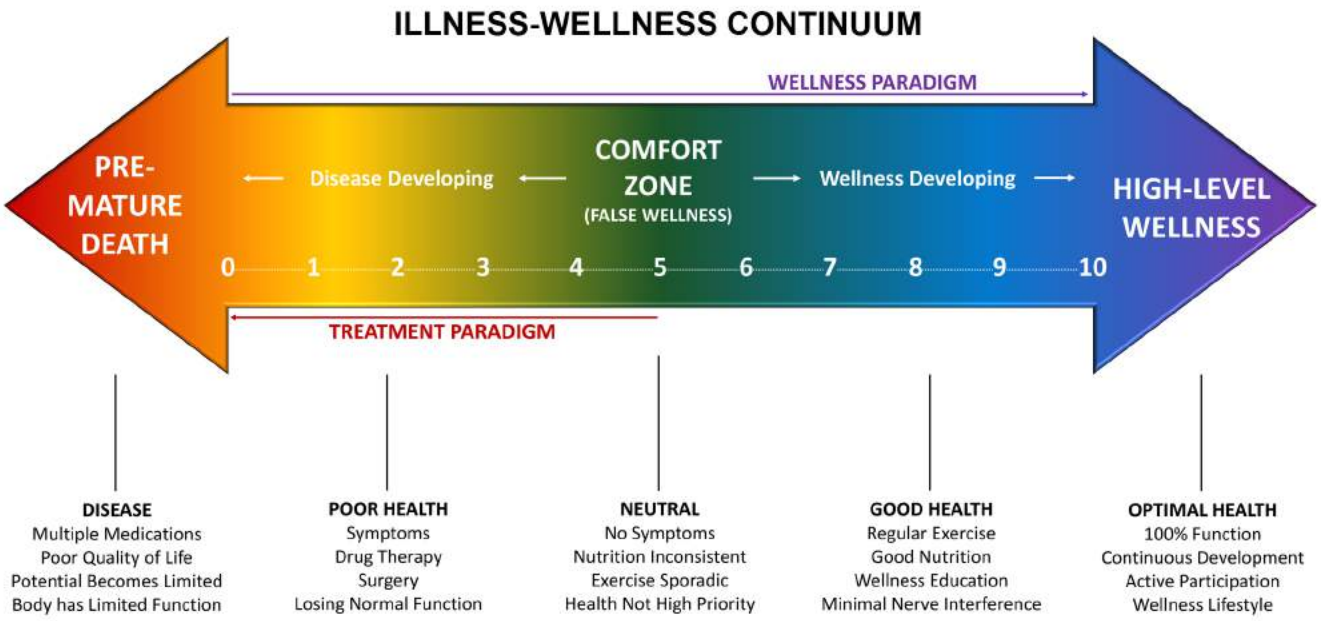
IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue? NOT COMMITTED (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

HEALTH & LIFESTYLE

Do you exercise? ☐ Yes ☐ No How often? _____ day(s) per week; Other: _____

What activities? ☐ Walking ☐ Running/Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other: _____

Do you smoke? ☐ Yes ☐ No How much? / How often? _____

Do you drink alcohol? ☐ Yes ☐ No How much? / How often? _____

Do you drink coffee? ☐ Yes ☐ No How much? / How often? _____

HEALTH CONDITIONS

CERVICAL SPINE (NECK)

Misalignment of the individual vertabrae or distortion of the complete cervical curve (neck) may result in many health conditions. Have you ever experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable :

- ____ Neck Pain
- ____ Pain in shoulders/arms/hands
- ____ Numbness/tingling in arms/hands
- ____ Hearing disturbances
- ____ Weakness in grip
- ____ Headaches
- ____ Dizziness
- ____ Visual disturbances
- ____ Coldness in hands
- ____ Thyroid conditions
- ____ Sinusitis
- ____ Allergies/Hay Fever
- ____ Reccurent colds/Flu
- ____ Low energy/fatigue
- ____ TMJ/pain/clicking
- ____ Lowered Immune Funtion
- ____ Anxiety

Please explain: _____

THORACIC SPINE (UPPER & MID BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable :

- ____ Heart palpitations
- ____ Heart murmurs
- ____ Tachycardia
- ____ Heart Attacks/Angina
- ____ Reccurent lung infections/Bronchitis
- ____ Asthma/wheezing
- ____ Shortness of breath
- ____ Pain on deep inspiration/expirations
- ____ Mid back pain
- ____ Pain in ribs/chest
- ____ Indigestion/Heartburn
- ____ Tired/irritable after eating
- ____ Hypoglycemia/Hyperglycemia
- ____ Nausea
- ____ Ulcers/Gastritis
- ____ Reflux
- ____ Diabetes

Please explain: _____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertabrae or distortion of the lumbar curve (low back) may result in many health conditions. Have you ever experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable :

- ____ Pain in hips/legs/feet
- ____ Numbness/tingling in legs/feet
- ____ Frequent/difficulty urinating
- ____ Constipation/Diarrhea
- ____ Weakness/injuries in hips/knees/ankles
- ____ Recurrent bladder infections
- ____ Muscle cramps in legs/feet
- ____ Menstrual irregularities/cramping
- ____ Low back pain
- ____ Coldness in legs/feet
- ____ Sexual dysfunction
- ____ Reproductive issues

Please explain: _____

OTHER HEALTH CONDITIONS / SURGERIES

Please list any other health conditions or past surgeries: _____

_____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages: _____

Childrens' health concerns: _____

Are you currently pregnant? ☐ No ☐ Yes, I am due: _____

Number of past pregnancies: _____

Health concerns regarding this pregnancy: _____

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes, whom? ☐ mother ☐ father ☐ grandmother ☐ grandfather ☐ sister ☐ brother ☐ son ☐ daughter

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list):	MEDICATIONS (list):	SUPPLEMENTS (list):

PAST CHIROPRACTIC CARE

Have you been under chiropractic care before? ☐ Yes ☐ No When was your last visit? _____

Who did you see? _____

Reason for visit: _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

_____ _____

Patient or Authorized Person's Signature **Today's Date**

Authorization & Assignment of Benefits to Precise Chiropractic Center

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges occurred at this office.
2. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.
3. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for your services of otherwise obligated to make payment to me or you based in whole or in part upon the charges for your services.
4. I give assignment lien against any claims against a third party whose negligence may have caused my injury, up to the bill for treatment.
5. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.
6. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such and authorize you to prosecute said action either in my name or your name as you see fit and further authorize you to comprise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you.
7. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.
8. I understand that interest is charged on overdue accounts at the annual rate of 16%. Accounts over 90 days past due will be sent to collections.

_____ _____

Patient or Authorized Person's Signature **Today's Date**

Terms of Acceptance and Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

● **Adjustment**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

● **Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

● **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.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. I have read and fully understand the above statements.

Chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

I therefore consent to the chiropractic examination and any further treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

I have also, read and understand the Precise Chiropractic Center Notice of Privacy Practices.

_____ _____

Patient or Authorized Person's Signature **Today's Date**