Patient Application Form

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team utilizing Advanced Muscular Integration Technique along with other specialized techniques that create spinal stabilization. These methods have enabled our patients to achieve their total health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you and are completely confident we can help you achieve your total health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become YOUR TOP PRIORITY. Thank you again for applying as a patient in our clinic.

____

Patient Name

____

Date Completed

Treatment Goals

- I want to find the problem and do whatever it takes to fix it. I don't want this to affect my long-term health.

- I want to know what the problem is and see what it will take to fix it. I am tired of hurting. I would like to fix it but money could be an issue.

- I just want an adjustment so I feel better.

Patient Information

Name: ______________________ (Age) __________ Gender: Male Female

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: __________

Have you seen a Chiropractor before? Yes No Who? ______________________

How did you respond? ______________________

How were you referred to this office? ______________________

Purpose For This Visit

Reason for this visit: ______________________

Is this related to an accident or specific injury (other than auto or work-related)*? Yes No If yes, when: ____/____/____

**If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: ______________________

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____/____/____ Are they: Constant Intermittent Activity-related

Are they getting worse? Yes No Do they interfere with: Work Sleep Hobbies Daily Routine

What activities aggravate your symptoms? ______________________

Is there anything that relieves your symptoms? Yes No If yes, explain: ______________________

Have you experienced these symptoms before (if not accident/injury related)? Yes No

If yes, explain: ______________________

Have you been treated for this? Yes No When were you last treated? ____/____/____

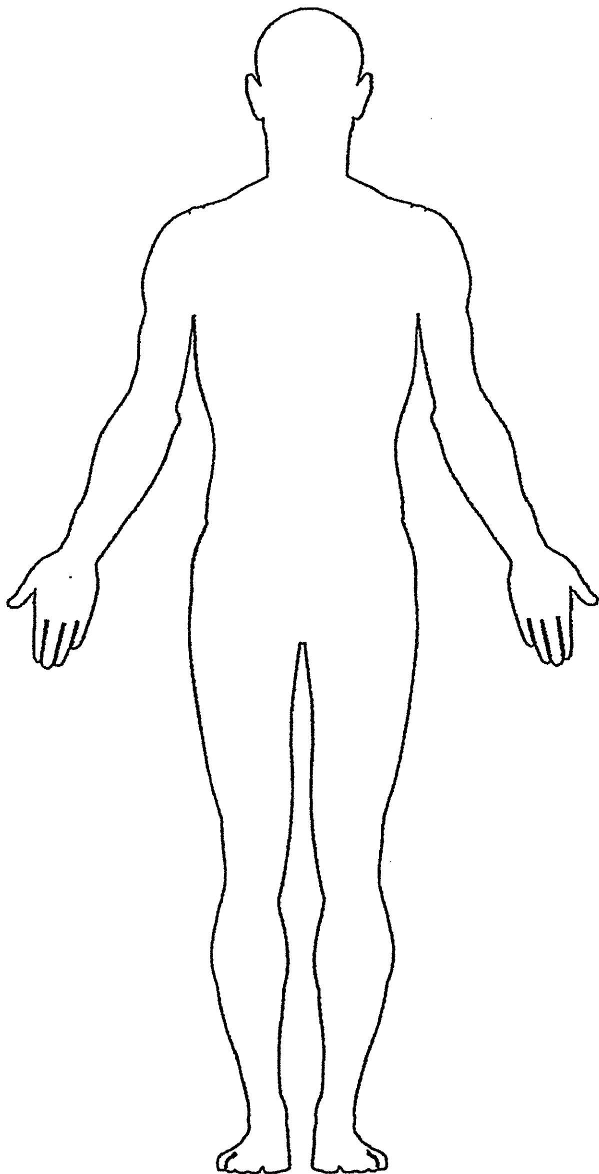
Who did you see? __________ What treatment was performed? __________

How did you respond? ______________________

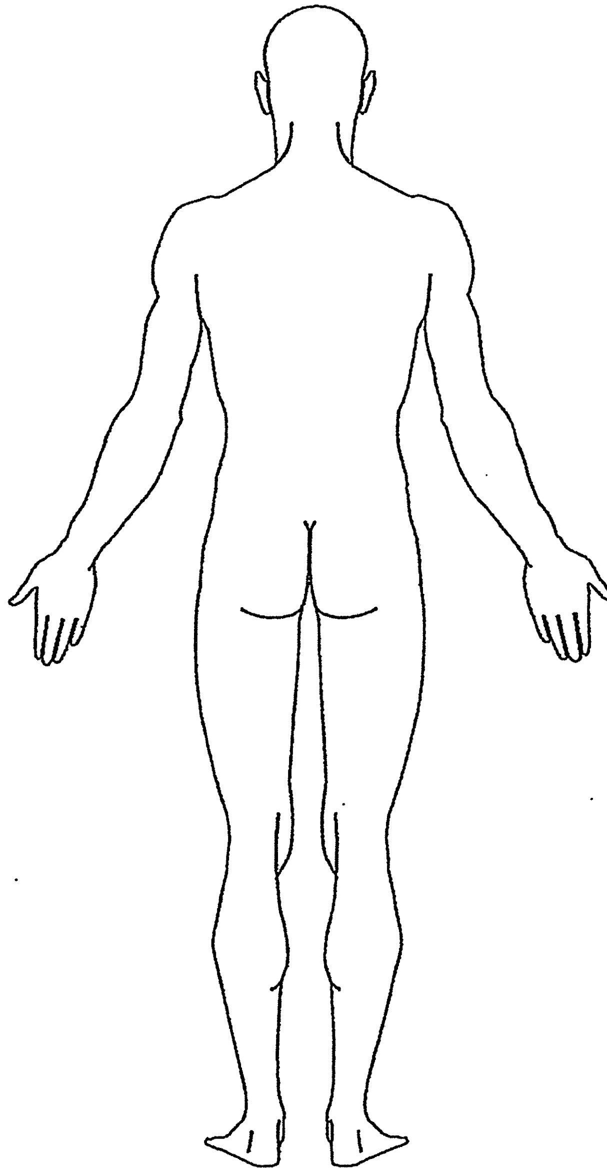
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

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____

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Review of Systems

Constitutional	Musculoskeletal	Neurological	Cardiovascular	Respiratory
O Fever	O Back Pain	O Sudden Numbness	O High Blood Pressure	O Asthma
O Weight Loss	O Headaches	O Sudden Headache	O Heart Disease	O COPD
O Obesity	O Extremity Pain	O Loss of Sensation	O Arterial Aneurysm	O Common Cold
O Loss of Appetite	O Bone Demineralization	O Confusion	O Angina	O Emphysema
O Fatigue	O Unstable Fracture	O Dizziness	O Irregular Heart Beat	O Pneumonia
O Anxiety	O Spinal Infection	O Slurred Speech	O Bleeding Disorder	O Cancer
O Allergies	O Spinal Bone Tumors	O Loss of Balance	O Heart Attack	O Pneumothorax
Eyes	**E, N, M, T**	**Genitourinary**	**Gastrointestinal**	**Disease History**
O Vision Troubles	O Hearing Loss	O Kidney Infection	O Diarrhea	O Stroke
O Double Vision	O Tinnitus	O Loss Bladder Control	O Blood in Stool	O Heart Attack
O Night Blindness	O Vertigo	O Urine Color Change	O Abdominal Pain	O Diabetes
O Glaucoma	O Nose Bleeds	O Painful Urination	O Liver/Gall Condition	O Cancer
O Cataracts	O Dry Mouth	O Urine Leakage	O Nausea/Heartburn	O HIV/AIDS
O Discharge	O Change in Taste	O Urgency	O Loss Bowel Control	
O Droopy Eyelids	O Bleeding Gums	O Blood in Urine	O Prostate Problems	

Past Health

List all of the prescription medications you are currently taking.

List all of the over-the-counter medications you are currently taking.

List all of the surgical procedures that you have had.

List all of the times you have been hospitalized.

List all significant past traumas that you have had.

Mark the following that are in your family history. O Heart Disease O Stroke/TIA O Diabetes O Cancer

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical 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 and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare 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 and/or staff'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.

Patient's Signature: ______________________________ Date _____/_____/_______

Patient's Name Printed: ______________________________

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded ______________________ County, State of Guardianship ______________

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature ______________________________ Date _____/_____/_______

In Case of Emergency

Name: ______________________________ Relationship: ______________

Work Phone: (   ) ____________ Home Phone: (   ) ____________ Cell Phone: (   ) ____________

Itemized Receipt's, AKA, "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your records.

Declaration

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 are strictly as a convenience to me. The doctor's 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 responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my Insurance company does not cover, if this is the case are you willing to pay for these services? Yes No

Patient's Signature: ______________________________ Date: _____/_____/_______

Signature of Person Authorizing Care (if different from patient):

______________________________ Date: _____/_____/_______

Relationship to Insured: ______________________ Date of Birth: _____/_____/_______

Employer: ______________________________

X-Ray Consent

The purpose for the x-rays about to be taken are to analyze the spine for vertebral subluxation and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing the x-rays, I will be informed. I understand that I must then make a determination to seek additional advice, diagnosis or treatment for the "unusual finding" from a health care provider. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ DOB ______/______/______

Print Patient Name

____ Date ______/______/______

Patient or Authorized Person's Signature

I, Parent/Legal Guardian, of a child, hereby grant permission for my child to receive chiropractic examination and x-rays.

____ Date ______/______/______

Parent/Legal Guardian

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______/______/______

Patient's Signature: ______________________________________ Date ______/______/______