

PATIENT APPLICATION FORM

Welcome to our clinic.

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. This allows our patients to achieve far superior results compared to most other systems.

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 assistance. We look forward to serving you.

Patient Signature

Date

Primary Care Physician/Family Doctor

Name: _____

Address: _____

Phone: _____

Fax: _____

PATIENT APPLICATION SURVEY

Name _____ Age _____ M/F _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____
Social Security # _____ Drivers License # _____
Birthdate _____ Marital Status _____ # of Children _____
Names of Children _____ Ages _____
How were you referred to this office? _____
Employer _____ Type of Work _____
Work address _____ Work Phone _____
Spouse's name _____ Age _____
Employer _____ Type of Work _____
Work Phone _____ Cell Phone _____

PURPOSE OF THIS VISIT

Current Complaint(s) _____
Is the purpose related to an auto accident? Yes No Work Injury? Yes No
Describe _____
When did this condition begin/when did you first notice it? _____
Describe _____
What aggravates your symptoms? _____
Is there anything that relieves 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? _____

EXPERIENCE WITH CHIROPRACTIC OR PHYSICAL THERAPY

Have you seen a chiropractor or physical therapist before? Yes No
Who? _____ When? _____
Reason for visits? _____
How did you respond? _____
Did you know your posture determines your health? Yes No
Are you aware of any of your poor postural habits? Yes No
Explain? _____
Are you aware of any poor postural habits in your spouse? Yes No
Explain? _____
Do you notice poor posture in your 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 entire 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

HEALTH LIFESTYLE

- Do you exercise? Yes No How often? _____
What activities? _____
Do you smoke? Yes No How much? _____
Do you drink alcohol? Yes No How much/week? _____
Do you drink coffee? Yes No How much/cups/day? _____
Other caffeinated beverages? Yes No How much/cups/day? _____
Do you take 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. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and other delicate nerves that pass between the vertebrae. These misalignments are called **Subluxations** (sub-lux-a-shuns). It has been extensively documented that subluxations, 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. The most common and detrimental postural distortion is called **Forward Head Syndrome** (a “**hunched forward**” posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain in your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay Fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Recurrent colds/Flus |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Pain/Clicking in jaws |

THORACIC SPINE (UPPER BACK):

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

- | | |
|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Recurrent lung infections/bronchitis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Heart attack/Angina | <input type="checkbox"/> Pain on deep inspiration/expiration (breathing) |

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 | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Pain in your ribs/chest | <input type="checkbox"/> Tire/irritable after eating or when you haven't eaten for a while | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Indigestion/Heart Burn | | <input type="checkbox"/> Ulcers/Gastritis |

LUMBAR SPINE (LOW BACK):

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Muscle Cramps in your legs/feet | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | |
| <input type="checkbox"/> Menstrual irregularities/cramping (females) | <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urination |

Please list any health conditions not mentioned above _____

Please list any medications or surgeries _____

Please list any traumas (falls, car accidents, sports, etc.) _____

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 Doctors 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 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 Signature

Date

Parent/Guardian

Date

IN CASE OF EMERGENCY CALL:

Name _____

Relationship _____

Work Phone _____

Cell Phone _____

Home 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. If this office chooses to bill any 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 the 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.

Patients Signature _____ Date _____

Guardian/Spouse's Signature Authorizing Care _____ Date _____

Name of Insurance Co. _____ Policy # _____

Address _____ Phone # _____

Insured's Name _____ Insured's SS# _____

Relationship to Insured _____ Birthdate _____

Employer _____ Phone # _____

WHO SHOULD RECEIVE CHARGES ON YOUR ACCOUNT?

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Spouse | <input type="checkbox"/> Parent/Guardian | <input type="checkbox"/> Workers Comp |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Personal Insurance | <input type="checkbox"/> Attorney | <input type="checkbox"/> Auto Insurance |