Better Health by Design
An Ideal Spine Center

Patient Application Form

VRC _____

Today's Date _____

Last Name _____ First _____ Middle Init _____

CIRCLE White☐ Asian☐ African Am☐ Hispanic☐ Other _____ Sex M☐ F☐ Birthday _____

Marital Status S☐ M☐ D☐ W☐ Occupation _____ Nickname _____

Address (Same as driver's license) ☐ Email _____

Address _____ Phone Home _____

City _____ Phone Work _____

State _____ Zip _____ Phone Cell _____

Referred by _____

Emergency Contact Name _____ Phone Number _____

Number of Children _____ Names and Ages _____

Method of Payment Insurance ☐ Self Pay ☐ Care Credit ☐ Med Pay ☐ Other _____

Have you had chiropractic care? Y☐ N☐ If yes, doctor and practice _____

When is the last time you had x-rays? _____ Females, are you pregnant? Y☐ N☐ IDK☐

Surgeries	**Traumas & Car Crashes**	**Social History**	**Vitamins & Supplements**	**Exercise, Sports, Phys Activity**	**Current Meds**
_____	_____	**Alcohol Y / N**	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	**Smoke Y / N**	_____	_____	_____
_____	_____	**per day:** _____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Broken Bones	_____	**Drugs**	_____	**How often?**	_____
_____	**Serious Illnesses**	_____	_____	_____	_____
_____	_____	_____	_____	_____	**Past Meds**
_____	_____	_____	_____	**Hobbies**	_____
_____	**Allergies**	**Fruits & Veggies**	_____	_____	_____
Implants	_____	_____ **serv/day**	_____	_____	_____
_____	_____	**Water**	**Sunlight**	_____	_____
_____	_____	_____ **cups/day**	_____ **min/day**	_____	_____

Family History Write **M** for Mother, **F** for Father, or **S** for Sibling if they have experienced any of the following:

High Blood Pressure	Heart Attack	Emphysema
Seizures/Convulsions	Asthma	Diabetes
Kidney Problems	Ulcers	Pace Maker/Defribrillator
Digestive Trouble	Stroke	Arthritis
Mental Illness	Thyroid Issues	Cancer
Osteoporosis	Autoimmune Disorder	Scoliosis

Is there anything else you would like to discuss with us or let us know?

_____

_____

Name _____ Date_____

Health History

Write N if you have experienced a condition NOW (within the past 3 months) OR
Write P if you have ever experienced a condition in the PAST, (prior to 3 months ago but not in the last 3 months).

Upper Neck

Headache	Migraines	Diff Concentrating	Irritability	Depression	Mood Swings
Skin Conditions	Frequently Sick	Visual Disturb	Double Vision	Blurry Vision	Sinus Problems
Ear Infections	Ears Ringing	Loss of Balance	Vertigo	Facial Pain	Smell / Taste Problems
Facial Numbness	Facial Tingling	Jaw Problems	TMD	Allergies	_____

Lower Neck

Neck Pain	Stiff Neck	Difficult Swallowing	Throat Problem	Hypo / Hyper thyroid	Shoulder Pain
Shoulder Weak	Shoulder Numb	Shoulder Tingling	Arm Pain	Arm Weakness	Arm Numbness
Arm Tingling	Hand Pain	Hand Weakness	Hand Numbness	Hand Tingling	Wrist Pain
Hands Hot / Cold	Swelling Joints	Arthritis	_____	_____	_____

Upper Mid-Back

Tension	Upper Back Pain	Chest Pain	Rib Pain	High BP	Heart Murmur
Arrhythmia	Palpitations	Heart Attack	Asthma	Allergies	Bronchitis
Difficulty Breathing	Shortness Breath	_____	_____	_____	_____

Lower Mid-Back

Upset Stomach	Ulcers	Gas / Bloating	Acid Reflux	High Cholesterol	Hypo / Hyper adrenal
Diff Losing Weight	Gall Bladder Pain	Diabetes	Diverticulitis	Fatigue	Hypo / Hyper glycemia
Mid Back Pain	Cold / Heat Intolerance		_____	_____	_____

Lumbar/ Low Back

IBS	Crohn's Disease	Constipation	Diarrhea	Frequent Urination	Uncontrolled Urination
Difficulty Urinating	Difficult Bowels	Hemorrhoids	Bladder Infections	Kidney Infections	Gout
Kidney Stones	Sexual Organ Dysfunction		Reproductive Dysfunction		LBP
Hip Pain	Hip Weakness	Hip Numbness	Hip Tingling	Leg Pain	Leg Weakness
Leg Numbness	Leg Tingling	Foot Pain	Foot Weakness	Foot Numbness	Foot Tingling
Ankle Pain	Knee Pain	Feet Hot / Cold	Swelling Joints	Arthritis	_____
_____	_____	_____	_____	_____	_____

Sleep _____ hours/night **Quality** Excellent ☐ Good ☐ Fair ☐ Poor ☐ Uninterrupted ☐ / Interrupted ☐ _____times/night

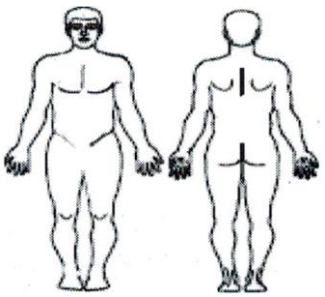
Notes _____
_____
_____
_____
_____
_____
_____

Name _____ Date_____

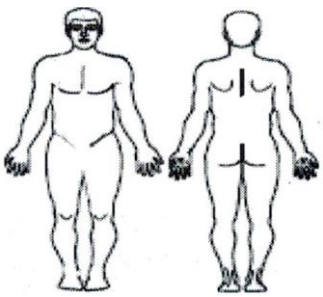
Nearly all of our patients reach wellness care to help maintain a new, improved level of living. Which would like to improve? ☐ Posture ☐ Sleep ☐ Mobility ☐ Fitness ☐ Stress Relief ☐ Focus ☐ Energy ☐ Nutrition ☐ Well-being ☐ Weight Other Health Goals _____

If you are currently experiencing any health challenges, place an X on the area of complaint and CIRCLE all that apply.

Main Health Concern 1) _____

Date Started	How	Type	Quality	Front	Back	Radiating	Timing	Severity
	Trauma	Pain	Sharp, Dull,			Head	Infrequent	Mild
_____	Repetitive	Numb	Aching, Stabbing			Neck	Occasional	Tolerable
	Unknown	Swelling	Throbbing,			Mid Back	Intermittent	Moderate
Date of	Post Surgical	Muscle	Crushing,			Low Back	Frequent	Severe
Flare Up/	Work	Spasms	Deep, Superficial,			R / L Arm	Constant	Disabling
Made Worse	Auto Crash	Headache	Local, Generalized,			R / L Hand		Now _____/10
	Insidious	Tension	Other _____			R / L Leg	% Time	Best _____/10
_____	Other	Tingling	_____			R / L Foot	Awake	Worst_____/10
	_____	Burning	_____			Other _____	_____%	Avg _____/10

Main Health Concern 2)_____

Date Started	How	Type	Quality	Front	Back	Radiating	Timing	Severity
	Trauma	Pain	Sharp, Dull,			Head	Infrequent	Mild
_____	Repetitive	Numb	Aching, Stabbing			Neck	Occasional	Tolerable
	Unknown	Swelling	Throbbing,			Mid Back	Intermittent	Moderate
Date of	Post Surgical	Muscle	Crushing,			Low Back	Frequent	Severe
Flare Up/	Work	Spasms	Deep, Superficial,			R / L Arm	Constant	Disabling
Made Worse	Auto Crash	Headache	Local, Generalized,			R / L Hand		Now _____/10
	Insidious	Tension	Other _____			R / L Leg	% Time	Best _____/10
_____	Other	Tingling	_____			R / L Foot	Awake	Worst_____/10
	_____	Burning	_____			Other _____	_____%	Avg _____/10

Check any Activities of Daily Living affected from your health issue(s) and RATE the severity and % limited.

Last 30 days

☐↑↓☐ Bending	Pain _____/10	_____% Ltd	☐↑↓☐ Reading	Pain _____/10	_____% Ltd
☐↑↓☐ Dancing	Pain _____/10	_____% Ltd	☐↑↓☐ Running	Pain _____/10	_____% Ltd
☐↑↓☐ Doing Chores	Pain _____/10	_____% Ltd	☐↑↓☐ Rolling Over	Pain _____/10	_____% Ltd
☐↑↓☐ Dressing	Pain _____/10	_____% Ltd	☐↑↓☐ Sit to Stand	Pain _____/10	_____% Ltd
☐↑↓☐ Driving	Pain _____/10	_____% Ltd	☐↑↓☐ Sitting	Pain _____/10	_____% Ltd
☐↑↓☐ Gardening	Pain _____/10	_____% Ltd	☐↑↓☐ Sleeping	Pain _____/10	_____% Ltd
☐↑↓☐ Lifting	Pain _____/10	_____% Ltd	☐↑↓☐ Watching TV	Pain _____/10	_____% Ltd
☐↑↓☐ Playing Sports	Pain _____/10	_____% Ltd	☐↑↓☐ Working	Pain _____/10	_____% Ltd
☐↑↓☐ Pushing	Pain _____/10	_____% Ltd	☐↑↓☐ Walking	Pain _____/10	_____% Ltd

FOR OFFICE USE ONLY

☐ Height _____ ☐ Weight _____ lbs
☐ Blood Pressure R / L _____ /_____ mmHg
☐ Resp. Rate _____ breaths/min
☐ Heart Rate _____bpm ☐ pO2 _____%
☐ Temp _____°F ☐ Shoe size _____ M W Y
☐ Posture _____

☐ PEF _____ L/min FEV1 _____ L/s
☐ Grip Dynamometry R _____ L _____
☐ Dynamometry
Region _____ L_____ R_____
Region _____ L_____ R_____

☐ SF-36 ☐ NDI
☐ RODI ☐ HDI
☐ DHI ☐ SRS-22
☐ UEFI ☐ LEFS
☐ RPQ ☐ HRV
☐ sEMG ☐ Therm

Refer to: ☐ MD ☐ PT ☐ DC For_____ ☐ Exam 99201 ☐ PT- RE Exam 97161 ☐ X-ray: 72020 # of films _____
☐ TENS: 97032 ☐ Laser: 97026 ☐ Ice: 97010 Other _____ Initial _____

HIPAA Authorization Form for Family and Friends

I, _____, give permission to all my health care service providers and payers to disclose and release my protected health information described below to:

Name(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab test(s), prognoses, treatment(s), and billing for all conditions)
  OR
- ☐ My complete record, as above stated, except for the following information (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS) records
  - ☐ Alcohol and(or) drug abuse records
  - ☐ Other (please specify) _____
    _____

This health information may be used to enable the persons I authorize to know and understand my condition(s), treatment(s), and(or) treatment option(s) for treatment or consultation, claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods
  OR
- ☐ Date or event: _____ unless I revoke it
  (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing)

_____ _____
Name of Individual giving this authorization Relationship to patient

_____ _____
Signature of individual giving this authorization Date

OFFICE POLICY

Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and the greatest benefits to their health.

CLINIC HOURS Initial _____

Monday, Wednesday, and Friday 7:00 AM-12:00 PM & 3:00 PM – 6:00 PM
Tuesday CLOSED
Thursday 3:00 PM -7:00 PM

APPOINTMENT SCHEDULING & MISSED APPOINTMENTS Initial _____

We have designed a specific course of action to allow proper care necessary for spinal and postural correction. A personal appointment calendar has been designed for you to save time on each visit. If an appointment must be changed, 24 hours notice is appreciated. All missed appointments should be made up later the same day or within 24 hours. Please let our front desk know and changes will be made accordingly.

BROKEN APPOINTMENTS Initial _____

No-show, no-call appointments are subject to a $25 charge. Please give 24 hours notice so that we may serve others in need at your time. If appointments are repeatedly missed, we will regretfully have to dismiss you from care.

CHILDREN & FAMILY Initial _____

Once you understand that the nervous system controls and coordinates all functions of the body and subluxation interferes with nerve flow, we expect that you would want everyone in your family checked for hidden damage in their spines. We have a cost-effective family program for you. We extend an opportunity for you to have your immediate family (within the same household) checked at a discounted fee within 14 days of starting care.

FINANCIAL AGREEMENTS Initial _____

It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you cannot keep your financial agreement, please inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

INTERRUPTION OF CARE Initial _____

In the unlikely event it is necessary to discontinue your care for any reason, any outstanding fees become payable and due immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

CHIROPRACTIC EXCELLENCE Initial _____

The doctors are occasionally out of the office to attend seminars and conferences to further their education. We will build your schedule around those times. If your doctor is out of the office, another doctor may be available to see you and provide care.

REMEMBER Initial _____

Spinal correction and healing takes time. If you do not feel satisfied with your body's responses, please make an appointment to discuss this with your doctor. We want you to get the most from your chiropractic care.

RESEARCH Initial _____

I hereby consent for my health information to be used for research health purposes.

REFERRALS Initial _____

The success of our office and the health of your loved ones greatly depend on your referrals. If there is someone you would like to have invited to our office, please let us know.

I, _____, have read and understand the above policies and agree to abide by them.

Signed _____ Date_____

Witness _____ Date _____

INFORMED CONSENT FOR CHIROPRACTIC

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as the relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column becomes misaligned and/or do not move properly. This causes alteration of the nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific instruments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter on-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____, being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his/her 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 _____

_____	_____	_____
Print Name	Signature	Date