WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal 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 recover your 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
Patient Information
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: ( ) ____________
Spouse's Employer: ___________________________ Occupation: ___________________________
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
Explain: ___________________________
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? ___________________________

Experience with Chiropractic
Have you seen a Chiropractor before? ❑ Yes ❑ No
Who? ___________________________
Reason for visit(s): ___________________________
Did your previous chiropractor take ‘before’ and ‘after’ x-rays? ❑ Yes ❑ No What was the diagnosis? ___________________________
Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No
If yes, what? ___________________________ How long were you treated? ________ Last treatment: _____ / _____ / _____
How did you respond? ___________________________
Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No
If yes, explain: ___________________________
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 = PINES & NEEDLES F = STIFFNESS      O = OTHER

FRONT

BACK

If you marked “O” for Other on any part, please explain below:
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? ________________________________

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

If yes, please list: ________________________________

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.1 Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine 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.

_____ Neck Pain
_____ Headaches
_____ Sinusitis
_____ Pain in 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

Please explain: ________________________________

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine 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
_____ Recurrent Lung Infections/Bronchitis
_____ Heart Murmurs
_____ Asthma/Wheezing
_____ Tachycardia
_____ Shortness Of Breath
_____ Heart Attacks/Angina
_____ Pain On Deep Inspiration/Expiration

Please explain: ________________________________

Health Conditions continued...

THORACIC SPINE (MID BACK)
Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine 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.

_____ Mid Back Pain  _____ Nausea  _____ Diabetes
_____ Pain in Ribs/Chest  _____ Ulcers/Gastritis  _____ Hypoglycemia/Hyperglycemia
_____ Indigestion/Heartburn  _____ Reflux
_____ Tired/Irritable after eating or when not having eaten for a while

Please explain: ________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

LUMBAR SPINE (LOW BACK)
Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine 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.

_____ Pain in hips/legs/feet  _____ Weakness/injuries in hips/knees/ankles  _____ Low back pain
_____ Numbness/tingling in legs/feet  _____ Recurrent bladder infections  _____ Coldness in legs/feet
_____ Frequent/difficulty urinating  _____ Muscle cramps in legs/feet  _____ Sexual dysfunction
_____ Constipation/Diarrhea  _____ Menstrual irregularities/cramping (females)

Please explain: ________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

OTHER

Please list any health conditions not mentioned: ______________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Please list any medications (include name, dose, for what condition, and how long you’ve been taking it): ______________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Please list any surgeries (include type of surgery and date it was performed): _____________________________
___________________________________________________________________________
___________________________________________________________________________
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## Family Health History

Have any of your family members ever been diagnosed with the following (please indicate “Y” for You, and “O” for Other than you, or both if applicable):

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<thead>
<tr>
<th>Disease/Condition</th>
<th>Y</th>
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<tbody>
<tr>
<td>Diabetes</td>
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<td>Rheumatic fever</td>
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<td>High Blood Pressure</td>
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<td>Kidney Disease</td>
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<td>Liver Disease</td>
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<td>Broken bones/fractures</td>
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<td>Pneumonia/ Bronchitis</td>
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<td>Whooping Cough</td>
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<td>Thyroid Problems</td>
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<td>Blood Sugar Problems</td>
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<td>Varicose Veins</td>
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<td>Small Pox</td>
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## Pregnancy Release

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   /   /   

## 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 doctors 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   

Guardian Signature   

Date   /   /   

## In Case of Emergency

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Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

ITEMIZED RECEIPTS, 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 personal 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 ____________________________________________

Primary Insurance Company ____________________________________________ Policy#__________________________

Address Phone # ( ) __________________________

Insured’s Name ____________________________________________ Insured’s Social Security #: _____ - _____ - ______

Secondary Insurance Company ____________________________________________ Policy#__________________________

Address Phone # ( ) __________________________

Insured’s Name ____________________________________________ Insured’s Social Security #: _____ - _____ - ______