SMITH family CHIROPRACTIC

Realigning Health and Wellness

PATIENT APPLICATION FORM

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 that helps our patients recover their optimal health; often where many other systems have failed. Because of this, we may not accept you as a patient until we are absolutely certain we know what is causing your condition, 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

Preferred Name: _____

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Date of Birth: ___/___/____ Marital Status: S M D W Preferred Contact: ___e-mail ___text ___phone (Circle: Cell Home Business)

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Children (Names and ages) _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit and related health problems: _____

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: _____

_____

_____

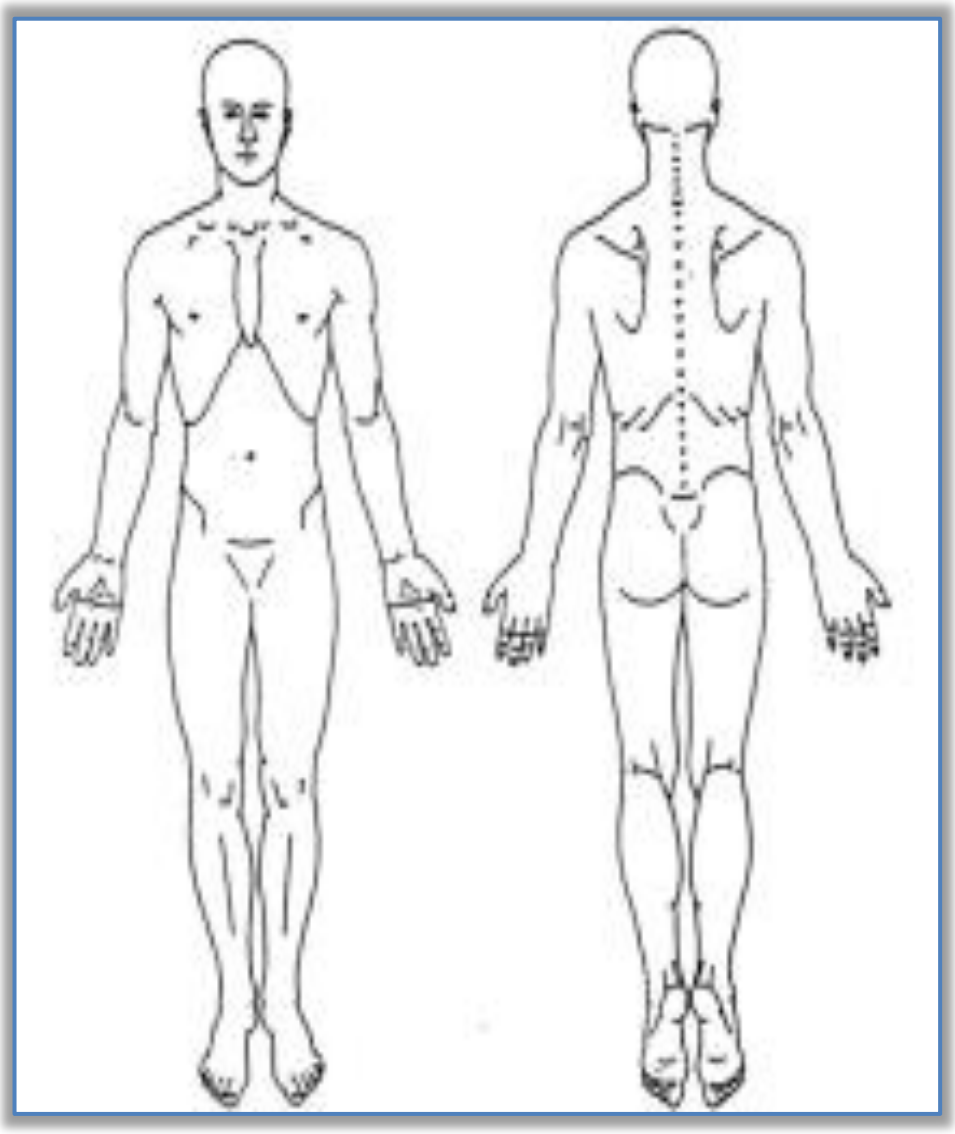
_____

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 = PINS & 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/tea/soda? ☐ Yes ☐ No How much? / How often? _____

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

_____

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 (B) = 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 (B) = 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: _____

_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

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 (B) = BOTH if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Diabetes
____ Hypoglycemia/Hyperglycemia
____ 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 (B) = 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 (females)
____ Low back pain
____ Coldness in legs/feet
____ Sexual dysfunction
____ Incontinence/Bladder leaking

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):

_____

_____

_____

_____

_____

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 "B" for both if applicable)***:

___Diabetes	___Varicose Veins	___Neurological Problems	___Lung Disease
___Rheumatic Fever	___Circulatory Problems	___Stroke	___Heart Murmur
___High Blood Pressure	___Heart Disease	___Cancer	___Osteoporosis
___Kidney Disease	___Paralysis	___Migraine Headaches	___Arthritis
___Liver Disease	___Metal Implants	___Infectious Disease	___Gall Bladder
___Broken bones/fractures	___Appendectomy	___Tonsillectomy	___Hernia
___Pneumonia/Bronchitis	___Polio	___Tuberculosis	___Anemia
___Whooping Cough	___Chicken Pox/Shingles	___Mumps	___Measles
___Thyroid Problems	___Small Pox	___Influenza	___Pleurisy
___Blood Sugar Problems	___Epilepsy/Seizures	___Eczema/Psoriasis	___Lumbago

___Other:_____

Radiograph Consent

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Smith Family Chiropractic and /or its associates and assistants to take spine or other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications published in the Practicing Chiropractor Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Patient's Signature/ or Guardian_____ **Date** _____ **/**_____ **/**_____

ALL FEMALES: I also certify that to the best of my knowledge I am not pregnant. I have been advised that x-ray can be hazardous to an unborn child. _____
Initial

Authorization of Care

If my case is accepted and I agree with the doctor's recommendation I authorize and agree to allow the doctor and/or his designated staff to work with my spine through the use of spinal adjustments and rehabilitative exercises, traction and other methods 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 Name Printed _____

Patient's Signature _____ Date ____/____/____

Guardian/Spouse's Signature Authorizing Care for Minor _____ Date ____/____/____

In Case of Emergency

NAME:_____ RELATIONSHIP:_____ PHONE:_____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 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 a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

Insurance

Other than yourself, who is responsible for your bill? (CHECK ALL THAT APPLY)
[ ] Spouse [ ] Parent/Guardian [ ] Workers Comp [ ] Auto Insurance [ ] Medicare [ ] Medicaid
Insurance Co. Name _____ Phone #_____
Policy# _____ Group #_____
Address_____
Insured's Name_____ Birth date: _____ /_____ /____ Relationship_____
For Automobile Accidents, what is the name of your Insurance Carrier?_____
Phone # _____ Policy Claim Number:_____

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. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred to 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.

HMO's limit their services to those they deem 'medically necessary' and are performed by a doctor that is employed by the insurance company ("in network".) This office does not participate with any insurance provider or accept such an assignment. This means we work for you- not the insurance company. This allows us to make recommendations based on what **you need**, not based on an insurance company's limited coverage. Please feel free to discuss fees and charges with the doctor. It is our policy that we discuss fees before services are provided.

If you are **not** part of an HMO please check the box if you would like this office to prepare them for you:
☐ **YES, I would like Superbills.**
☐ **I have a Health Savings account, Health Reimbursement account, or Flex Spending Card.**
☐ **NO, I do not need Superbills.**

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, 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 this is done strictly as a **convenience** and **courtesy** for me. (We will only bill the insurance one time for a Date of Service at no charge to the patient.) This office may provide any necessary reports subject to reasonable service fees 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 I am willing to pay for these services.

Patient's Signature _____ Date ____/____/____

HEALTHCARE AUTHORIZATION FORM
(HIPAA)

THE FOLLOWING AUTHORIZES SMITH FAMILY CHIROPRACTIC AND ASSOCIATES TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Smith Family Chiropractic and Associates to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Smith Family Chiropractic and Associates to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving Smith Family Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: _____ Date:

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures; I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent.
* The right to object to the use of my health care information for directory purpose.
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature of Patient/or Guardian:_____Date: ____/____/____

By your own request we are able to share personal health information. Are there any family members or individuals you would like to authorize to view your personal and private health information (Including appointment times, health information from this clinic or others that we have received, etc.?)

I would like to share my personal health file and appointment times with:
(if none write n/a)

_____

_____

May we share records with Primary Care Physician? Yes or No

Primary Care Physician' s name: _____ ___

Signature of Patient/or Guardian:_____Date: ____/____/____