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. Our approach is very unique and advanced from other rehabilitative 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

_____

Today's Date

Name: _____ Age: _____ Gender: M F
Home Address: _____ Home Phone: ( )_____
City, State, Zip: _____ Cell Phone: ( )_____
Occupation: _____ Employer: _____
Email address: _____ Office Phone: ( )_____
Birth Date: _____ Soc. Security #: _____ Marital Status: S M D W
Names of Children: _____ Ages: _____
Spouse or Emergency contact: _____ Phone: ( )_____
How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

_____

Is this purpose related to an auto accident/work injury? Yes No If so, when? _____
When did this condition begin?_____ Did it begin: Gradual Sudden Progressive over time
What activities aggravate your symptoms? _____
Is there anything that relieves your symptoms? Yes No Describe: _____
Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting
Does the pain radiate into your: Arm Leg Does not Radiate Is this condition getting worse? Yes No
How often do you experience these symptoms throughout the day? 100% 75% 25% 10% Only with Activity
Does complaint(s) interfere with work sleep hobbies daily routine Explain: _____
Have you experienced this condition before? Yes No If so, please explain: _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who?_____ When?_____
Reason for visits: _____
How did you respond? _____
Did your previous chiropractor take before and after x-rays? Yes No
Did you know that posture determines your health? Yes No
Are you aware of any of your poor posture habits? Yes No
Explain: _____
Are you aware of any poor posture habits in your spouse or 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 whole body.) Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____
What activities? Run/jog Weight Train Yoga Cycling Pilates Swimming Other: _____
Do you smoke? Yes No If yes, how much? _____
Do you drink alcohol? Yes No If yes, how much per week? _____
Do you drink coffee? Yes No If yes how many cups a day? _____
Do you take supplements? (vitamins, minerals, herbs?)_____
_____
What position do you sleep in? Back Side Stomach How many hours per night? _____

HEALTH CONDITIONS

Abnormal postural habits or distortionsare 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 the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations. It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine, producing many serious and adverse effects on your overall health.

Please check any health condition you may be experiencing now, or in the past on the next page.

INFORMED CONSENT

I clearly understand that all insurance coverage is an arrangement between my insurance carrier (auto or medical) and myself. If this office chooses to bill any services that were performed to my insurance carrier, this is done so strictly as a convenience to me. Select Health and Wellness will provide any necessary report or required information to aid in insurance reimbursement of services, which may be subject to an administration fee; but I understand that insurance carriers may deny any claim, and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any workers compensation case that is active, or has not been finalized, and this office will not bill as such.

I hereby authorize physicians and staff at Select Health and Wellness to treat my condition as deemed appropriate. It is understood and agreed that the amount paid for x-rays, is for examination only and the x-ray will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the previous information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Select Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness: Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and active rehabilitation. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury: Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Stroke: Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol 37 No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems: There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic, that I will not receive the full benefit from the programs offered, 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 Select Health and Wellness for services rendered. I also understand any sum of money paid under assignment by my insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to Select Health and Wellness.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I herby give my informed consent to have chiropractic treatment administered.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature and consent Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and physicians at Select Health and Wellness have my permission to perform an x-ray evaluation. I have been advised that x-ray can hazardous to an unborn child.

_____ _____

Patient Signature Date

Consent to X-ray

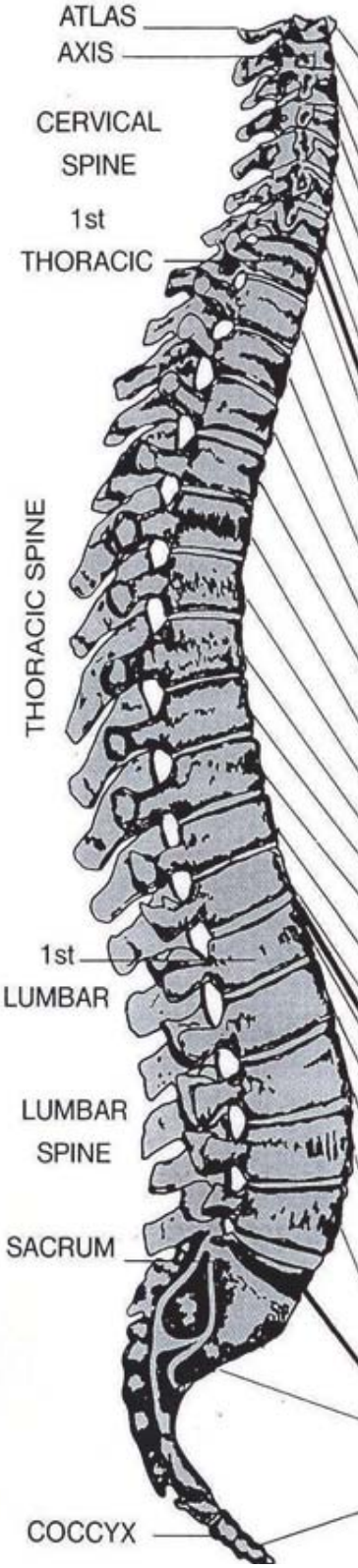
I hereby grant Select Health and Wellness permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____ _____

Patient Signature Date

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy*, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction (Check all that apply)	
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.	NECK REGION
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.	
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.	
4C	Nose, lips, mouth, eustachian tube.	☐hay fever,☐runny nose,☐hearing loss,☐adenoids.	
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.	
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.	
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.	
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.	MID-BACK
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.	
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.	
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.	
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.	
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.	
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.	
8T	Spleen.	☐ lowered resistance.	
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.	
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.	
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.	
12T	Small intestines, lymph circulation.	☐rheumatism,☐gas pains, ☐certain types of sterility.	
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.	LOW BACK
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.	
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.	
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.	
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.	
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.	PELVIS
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.	

Please list any health conditions not mentioned:

Please list all past surgeries:

Please list any medications currently taking and their purpose:

Please list all previous accidents and falls:

Select
Health and Wellness

Our main goal at Select Health and Wellness is to help you "live a life without limits."
Share ten goals you have for your life, your future and your health.

1._____
_____

2._____
_____

3._____
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4._____
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5._____
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6._____
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9._____
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10._____
_____

_____
Name

_____ _____
Signed Date

"The only limitations you will ever have are the ones you put on yourself."
– Kristinna Habashy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practices and understand the Privacy Protection Act.

_____

Print Name

_____

Signature

_____

Date

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options):

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements/or correspondence from our office to be mailed if ***other than your home.*** **(Confidential Communications)**

_____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "**CONFIDENTIA**L"Yes_____ No_____

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