

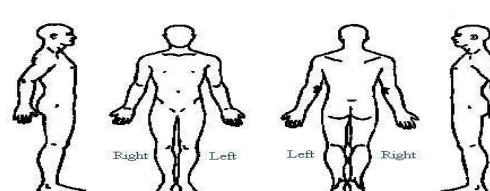

Healing Touch
 Family Chiropractic, P.C.
APPLICATION FOR CARE

PATIENT INFORMATION	
Date _____	
Patient Name _____	Last Name _____
First Name _____	Middle Initial _____
SS# _____	
E-mail _____	
Address _____	
City _____	
State _____ Zip _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____	
Birthdate _____	
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Minor	
Patient Employer/ School _____	
Occupation _____	
Spouse's Name _____	
Spouse's Birthdate _____	
Spouse's SS# _____	
Spouse's Employer _____	
Names & ages of children _____	
How were you referred to this office? _____	

INSURANCE INFORMATION
Primary Insurance Co. _____
Subscriber's Name _____
Relationship to patient _____
Subscriber's Birthdate _____
Subscriber's SS# _____
Subscriber's Address _____
Subscriber's employer _____
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Insurance Co. _____
Subscriber's Name _____
Relationship to patient _____
Subscriber's Birthdate _____
Subscriber's SS# _____
Subscriber's Address _____
Subscriber's employer _____
Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Healing Touch Family Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above name doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.
Signature of patient/parent _____
Print name of patient/parent _____

PHONE NUMBERS
Home # _____ Cell # _____
Best time & place to reach you _____
In case of emergency contact _____
Home # _____ Cell # _____

ACCIDENT INFORMATION
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other
To who have you made a report of your accident?
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker Comp <input type="checkbox"/> Other

PATIENT CONDITION
Reason for this visit _____
How often do you experience your symptoms?
<input type="checkbox"/> Constantly (76-100% of the time) <input type="checkbox"/> Occasionally (26-50% of the time)
<input type="checkbox"/> Frequently (51 -75 % of the time) <input type="checkbox"/> Intermittently (1-25 % of the time)
How would you describe the type of pain?
<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting
<input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling
<input type="checkbox"/> Diffuse <input type="checkbox"/> Shooting w/motion <input type="checkbox"/> Stabbing w/ motion <input type="checkbox"/> Electric like w/ motion <input type="checkbox"/> Other: _____
How are your symptoms changing with time?
<input type="checkbox"/> Getting worse <input type="checkbox"/> Staying the Same <input type="checkbox"/> Getting Better
Indicate on the drawings below where you have pain/symptoms:




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PATIENT CONDITION CONTINUED

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

How much has the problem interfered with social activities?

Not at all A little bit Moderately Quite a bit Extremely

Who else have you seen for your problem?

Chiropractor Neurologist Primary Care Physician ER physician Orthopedist
 Massage Therapist Physical Therapist Other: _____ No one

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem severe?

Yes Yes, at times No

What aggravates your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

Weight _____ Age _____

Have you seen a chiropractor before? Yes No Who? _____

When? _____

Reason for visits? _____ How did you respond? _____

Did you know that your posture determines your health? Yes No

Are you aware of poor postures in you, your spouse, or 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 whole body). Even less severe forms of this posture can cause many adverse affects on your overall health.

Have you ever been told or feel that you carry your head forward? Yes No

How would you rate your overall health?

Excellent Very Good Good Fair Poor

What type of exercise do you do?

Strenuous Moderate Light None

Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis Diabetes Lupus Heart Problems

Cancer ALS

List all prescription medications you are currently taking: _____

List all of the over-the-counter medications, herbs, vitamins, minerals, or supplements you are currently taking: _____

List all surgical procedures you have had: _____

What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer Work	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the Phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day

What activities do you do outside of work? _____

Have you ever been hospitalized? No Yes If yes, why? _____

Have you had significant past trauma? No Yes If yes, describe _____



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HEALTH HISTORY CONTINUED

A **Subluxation** is when one or more of the bones of the spine become misaligned which may cause irritation to the spinal cord, or spinal nerves. Untreated subluxation may cause weakened or distorted postures. Subluxations and postural distortion may be linked to the following health conditions. Please check any health conditions that you are experiencing or have had in the past.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Tumor
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Other: _____
For Females Only					
<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy <input type="checkbox"/> Other : _____

Is there anything else pertinent to your visit today?

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the County Health Department's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state laws. I understand the contents of the Notice, and I request the following restrictions concerning the use of my personal medical information.

Signed: _____ Date: _____

*If not signed by the patient, please indicate your relationship to the patient (e.g., spouse, parent, etc.)

Relationship: _____

Witnessed by: _____

Internal Use Only: If a patient or patient's representative refused to sign the following Acknowledgement Receipt of Notice, please document the date and time the notice was presented to the patient and sign below.

Presented on: _____ By: _____ Title: _____