NEW PRACTICE MEMBER APPLICATION

Name:_____Date of Birth: _____/_____ /_____ Age:_____ □ Male □ Female

Address:_____ City:_____ State:_____ Zip:_____

Phone: Cell_____Home:_____

Email Address:_____ Social Security #:_____

Occupation:_____ Employer:_____

Status: □ Single □ Married □ Divorced □ Widowed - Spouse's Name:_____ # of Children:_____

Names, Ages, &Gender:_____

How did you hear about us? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW

Health Concern: (List according to severity)	**Rate of severity** 0 = no pain 10 = unbearable	**When did this problem start?**	**Have you had the problem before? If so, when?**	**Did the problem begin with an injury?**	**Are symptoms Constant (C) Intermittent (I)?**
First:					
Second:					
Third:					
Fourth:					

Have you seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical Doctor □ Other: _____

Who?_____When?_____Results? _____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

____Headaches	____Ear Infections	____Sinus Issues	____Kidney Problems	____Sexual Dysfunction
____Migraines	____Hearing Loss	____Frequent Colds	____Bladder Problems	____Sleep Problems
____Jaw/TMJ Pain	____Ringing in the Ears	____Thyroid Issues	____Menstrual Problems	____Tight/Sore Muscles
____Neck Pain	____Dizziness	____Asthma	____Prostate Problems	____Sports Injury
____Shoulder Pain	____Loss of Energy	____Chest Pain	____Infertility	____Sciatica
____Arm Pain	____Nervousness	____Heart Problems	____Fibromyalgia	____Arthritis/Joint Pain
____Upper Back Pain	____Double/Blurry Vision	____Nausea	____Epilepsy/Convulsions	____GERD/Gastric Reflux
____Mid Back Pain	____Anxiety	____Ulcers	____Tremors	____Numb/Tingling in Arms/Hands
____Lower Back Pain	____ADD/ADHD	____Digestive Issues	____Disc Problems	____Numb/Tingling in Legs/Feet
____Hip/Leg Pain	____Loss of Balance	____Diarrhea	____Scoliosis	____Stomach Problems
____Knee Pain	____Depression	____Constipation	____Poor Posture	____High/Low Blood Pressure
____Foot Pain	____Allergies	____Bed Wetting	____Skin Problems	____Difficulty Breathing

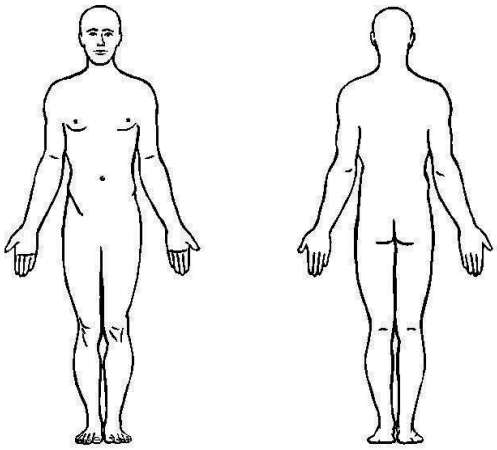
Pregnant? □ Yes □ No If yes, Due Date? _____

Other(s): _____ _____ _____

____Stroke ____Cancer ____Heart Attack ____Spinal Surgery ____Diabetes

Spinal Bone Fracture _____Scoliosis ____Arthritis ____Seizures Other:___

PLEASE MARK the areas on the diagram with the following LETTER(S) to describe your symptoms:



R= Radiating **B**= Burning **D**= Dull **A**= Aching

N= Numbness **S**=Sharp/Stabbing **T**=Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

When is (are) the problem(s) at its worst? AM PM Mid-Day Late PM

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about: _____

List all over the counter & prescription medications you are on, & the reason for each: _____

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe: _____

Other trauma: _____

Social History

1. Smoking: How often? □Daily □ Weekends □Occasionally □ Never
2. Alcohol: How often? □Daily □ Weekends □Occasionally □ Never
3. Exercise: How often? □Daily □ Weekends □Occasionally □ Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours? □ Yes □No

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No Pain (Back pain: 2, Headaches: 7) Worst Possible Pain

0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best?_____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst?_____%

PLEASE PRINT NAME HERE **DATE**

FOR OFFICE USE: Q1_____+ Q2_____+ Q4_____=_____/3x10=_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Sit to Stand	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Carry Groceries	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Climbing Stairs	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Pet Care	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Driving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Extended Computer Use	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Household Chores	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Lifting Children	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Dressing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sexual Activities	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sleeping	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Sitting	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Static Standing	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Walking	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Washing/Bathing/Shaving	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Sweeping/Vacuuming	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Yard work	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Garbage	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Concentration (Reading)	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform
Other_____	□ No Effect	□ Painful (can do)	□ Painful (limits)	□ Unable to Perform

TELL US YOUR STORY - WHAT IS HAPPENING AND WHY IS IT IMPORTANT THAT YOU HEAL?

_____

_____

_____

_____

_____

_____

PLEASE PRINT NAME HERE_____ **DATE**_____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer’s					

PLEASE PRINT NAME HERE

DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occuring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Dr. Drew Kirkpatrick, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

PRINT NAME

PATIENT SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: _____

I authorize Dr. Drew Kirkpatrick and any and all Health Co. Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Health Co. Chiropractic.

GUARDIAN SIGNATURE **DATE**

RELATIONSHIP TO MINOR/CHILD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

SIGNATURE **DATE**

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. There is no fee for a requested copy of x-rays. However, advanced notice is appreciated. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Health Co. Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions..

PRINT NAME HERE **DATE OF BIRTH**

SIGNATURE **DATE**

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Provision Chiropractic.

SIGNATURE **DATE**