TOTAL HEALTH
SPINE & NUTRITION

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 a TOP PRIORITY. Thank you again for applying as a patient in our clinic.

____

PATIENT NAME

____

DATE COMPLETED

TOTAL HEALTH
SPINE & NUTRITION

Date: ______________________

PERSONAL INFORMATION

First Name: ______________________________ MI ____ Last Name: ____

Address: ____ Cell Phone: ___________________________

City/State/Zip: ____ Home Phone: ___________________________

*Email (required): ____ Work Phone: ___________________________

*You will automatically be enrolled to receive **protected** health records through **Patient Fusion**. This allows you to gain online access to your medical records.

Social Security #: ________________________________ Birth Date: _____ / _____ / _____ Age: _______ Gender: • M F

Marital Status: • S • M • D • W Spouses Name: _________________________________ # of Children: ________

Occupation: ____________________________________ Employer's Name: _____________________________________

Work Address: __________________________________ City/State/Zip: ____

How were you referred to our office?: • TV Drive By Internet • Insurance Co.

Friend/Family: _________________________ Other: ____________________

Do you have a Primary Care Physician? Yes No Name: ______________________________ Phone: _____________

Address: ____ City/State/Zip: __________________________________

Have you ever seen a Chiropractor Before? • Yes • No If Yes, When: ______________________________________

Where: ____ Results: ____

Please List Your TOP 3 Complaints/Symptoms

Complaint #1	Type of Pain:		Worse with which of these activities:		Result of:
________________________ ________________________ Began?: ________________ Have you had this in the past? ❑ Yes • ❑ No Is it Getting Worse? ❑ Yes • ❑ No ❑ Constant	❑ Aching ❑ Burning ❑ Deep ❑ Dull ❑ Numb ❑ Sharp/ Stabbing	❑ Tight ❑ Stiff ❑ Tender ❑ Tingling ❑ Throbbing ❑ Shooting ❑ Sore	❑ Lying on back ❑ Lying on side ❑ Lying on stomach ❑ Turning over ❑ Getting in/out of car ❑ Dressing self ❑ Pushing ❑ Pulling ❑ Lifting ❑ Reaching	❑ Stooping ❑ Bending ❑ Twisting/Turning ❑ Sitting ❑ Standing ❑ Walking ❑ Climbing ❑ Sneezing ❑ Coughing ❑ Other: __________	❑ Auto Accident ❑ Work Injury ❑ Other (Describe): ______________ ______________
Complaint #2	**Type of Pain:**		**Worse with which of these activities:**		**Result of:**
________________________ ________________________ Began?: ________________ Have you had this in the past? ❑ Yes • ❑ No Is it Getting Worse? ❑ Yes • ❑ No ❑ Constant	❑ Aching ❑ Burning ❑ Deep ❑ Dull ❑ Numb ❑ Sharp/ Stabbing	❑ Tight ❑ Stiff ❑ Tender ❑ Tingling ❑ Throbbing ❑ Shooting ❑ Sore	❑ Lying on back ❑ Lying on side ❑ Lying on stomach ❑ Turning over ❑ Getting in/out of car ❑ Dressing self ❑ Pushing ❑ Pulling ❑ Lifting ❑ Reaching	❑ Stooping ❑ Bending ❑ Twisting/Turning ❑ Sitting ❑ Standing ❑ Walking ❑ Climbing ❑ Sneezing ❑ Coughing ❑ Other: __________	❑ Auto Accident ❑ Work Injury ❑ Other (Describe): ______________ ______________
Complaint #3	**Type of Pain:**		**Worse with which of these activities:**		**Result of:**
________________________ ________________________ Began?: ________________ Have you had this in the past? ❑ Yes • ❑ No Is it Getting Worse? ❑ Yes • ❑ No ❑ Constant	❑ Aching ❑ Burning ❑ Deep ❑ Dull ❑ Numb ❑ Sharp/ Stabbing	❑ Tight ❑ Stiff ❑ Tender ❑ Tingling ❑ Throbbing ❑ Shooting ❑ Sore	❑ Lying on back ❑ Lying on side ❑ Lying on stomach ❑ Turning over ❑ Getting in/out of car ❑ Dressing self ❑ Pushing ❑ Pulling ❑ Lifting ❑ Reaching	❑ Stooping ❑ Bending ❑ Twisting/Turning ❑ Sitting ❑ Standing ❑ Walking ❑ Climbing ❑ Sneezing ❑ Coughing ❑ Other: __________	❑ Auto Accident ❑ Work Injury ❑ Other (Describe): ______________ ______________

HEALTH & LIFESTYLE

Is this condition interfering with your (Check all that apply):

❑ Work ❑ Sleep ❑ Daily Routine ❑ Other: ______________________

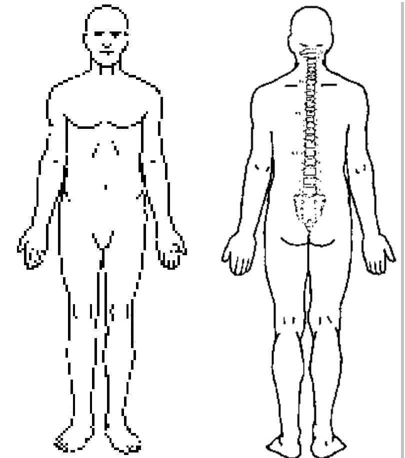
Have you received any treatment for this condition? • Yes • No

If Yes, please explain____

Have you been in an auto accident (Check all that apply): •

❑ Past year ❑ Past 5 years ❑ Over 5 years ❑ Never

Please "X" your areas of pain on the figures below:



HABITS

❑ Smoking Packs/Day: ____________________

❑ Alcohol Drinks/Day: ____________________

❑ Coffee Cups/Day: ____________________

❑ Soft Drinks Drinks/Day: ____________________

❑ Water Glasses/Day: ____________________

❑ Vitamins List: ____________________

EXERCISE

❑ None

❑ 1-2 days/week

❑ 3-4 days/week

❑ 5+ days/week

Type of Exercise:

____

____

EMERGENCY CONTACT

Name: ______________________________ Relation: ______________________________

Cell/Home Phone: ______________________________ Work Phone: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

ELECTRONIC HEALTH RECORDS (EHR) INFORMATION

Demographics

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Preferred Language: ❑ English ❑ Spanish ❑ Other: ____________________

Race: ❑ White/Caucasian ❑ African American ❑ Native American ❑ Hawaiian/Pacific ❑ Asian ❑ Other: ________________

Are you allergic to any medications? Yes No

If yes, please list those medications and the problem experienced?

____

____

____

Do you smoke now? Yes No

Have you ever been a smoker? Yes No

Use any other form of tobacco? Yes No

CHECK THE FOLLOWING HEALTH CONDITIONS AS THEY APPLY TO YOU

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 if you have had any of these conditions in the Past, Now, or Both.

Past	Now		Past	Now		Past	Now	
❑	❑	Neck Pain	❑	❑	Low energy/fatigue	❑	❑	Sinus congestion/infections
❑	❑	Pain in shoulders/arms/hands	❑	❑	Nervousness	❑	❑	Hearing disturbances
❑	❑	Numbness/tingling in arms/hands	❑	❑	Anxiety/Depression	❑	❑	Visual disturbances
❑	❑	Weakness in grip	❑	❑	Sleep problems	❑	❑	Dizziness/vertigo
❑	❑	Cold hands	❑	❑	Recurrent Colds/Flu	❑	❑	Thyroid conditions
❑	❑	Headaches/Migraines	❑	❑	Allergies/hay fever	❑	❑	TMJ/Pain/Clicking

Please explain: ____

____

____

HEALTH CONDITIONS CONTINUED…

THORACIC SPINE (MID AND UPPER BACK)

Misalignment of the individual vertebrae or distortion of the thoracic curve (upper and mid back) originating in the 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 if you have had any of these conditions in the Past, Now, or Both.

Past	Now	
❑	❑	Upper Back Pain/Stiff/Tight
❑	❑	Mid Back Pain/Stiff/Tight
❑	❑	High blood pressure
❑	❑	Tachycardia (racing heart)
❑	❑	Palpitations
❑	❑	Heart Attacks/Angina
❑	❑	Heart Murmurs

Past	Now	
❑	❑	Shortness of breath
❑	❑	Asthma/wheezing
❑	❑	Lung Infections/Bronchitis
❑	❑	Pain w/ deep breaths
❑	❑	Pain in ribs/chest
❑	❑	Heartburn/Reflux
❑	❑	Tired/irritable after eating or when not having eaten for awhile

Past	Now	
❑	❑	Ulcers
❑	❑	Gas
❑	❑	Bloating
❑	❑	Stomach aches/cramping
❑	❑	Diabetes
❑	❑	Gall Bladder Problems

Please explain: ____

____

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LUMBAR SPINE/PELVIS (LOW BACK/HIPS)

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 if you have had any of these conditions in the Past, Now, or Both.

Past	Now	
❑	❑	Low Back Pain
❑	❑	Pain in the hips/legs/feet
❑	❑	Numbness/Tingling in legs/feet
❑	❑	Cold feet
❑	❑	Weakness/injuries in hips/ knees/ankles

Past	Now	
❑	❑	Muscle cramps in leg/feet
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Recurrent bladder infections
❑	❑	Frequent/difficulty urinating
❑	❑	Kidney stones

Past	Now	
❑	❑	Sexual dysfunction
❑	❑	Unable to control urine
❑	❑	(Females) Irregular cycles/ cramping
Y	N	Pregnant at this time?
________		Last menstrual cycle?

Please explain: ____

____

____

ADDITIONAL INFORMATION

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

____

____

____

____

Please list any health conditions, diseases, or surgeries that you have or ever had (cancer, pacemaker, liver trouble, mental disorders, multiple sclerosis, epilepsy, HIV, etc): ____

____

____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Using the scale below please circle one answer in each box that indicates your ability to do the following activities:
Scale: (0 = no difficulty) (1 = minimally difficult) (2 = somewhat difficult) (3 = moderately difficult) (4 = very difficult) (5 = unable)

Activity	Score					
1. Sleep normally	0	1	2	3	4	5
2. Up and down stairs	0	1	2	3	4	5
3. Food prep, cooking, eating	0	1	2	3	4	5
4. Walking	0	1	2	3	4	5
5. Grooming (bath, comb hair, shave, etc.)	0	1	2	3	4	5
6. Getting up and down from chair or bed	0	1	2	3	4	5
7. Dressing - manage normal dressing activities	0	1	2	3	4	5
8. Dressing - tie shoes, buttons shirt	0	1	2	3	4	5
9. Lifting, carrying up to 10 pounds	0	1	2	3	4	5
10. Sitting for normal periods of time	0	1	2	3	4	5
11. Standing for normal periods of time	0	1	2	3	4	5
12. Reaching above head or across body	0	1	2	3	4	5
13. Leisure, recreational, sports activities	0	1	2	3	4	5
14. Squatting down to pick up item	0	1	2	3	4	5
15. Running, jogging	0	1	2	3	4	5
16. Driving	0	1	2	3	4	5
17. Job requirements - can do all activities required of my job	0	1	2	3	4	5

Pain Scale: Please **circle the number** that describes the pain you have experienced **over the last week** with (0) being no pain and (10) the worst imaginable pain:

0	1	2	3	4	5	6	7	8	9	10

What activities are your symptoms **affecting or preventing you from doing:** ________________________________

____

FAMILY HISTORY

Please √ all that apply

	Stroke	Bad Posture	Heart Trouble	High Blood Pressure	Cancer	Multiple Sclerosis	Headaches	Neck Problems	Back Problems	Disc Problems	Diabetes	Arthritis	Pinched Nerve	Osteoporosis	Scoliosis
Father															
Mother															
Brother															
Sister															
Child															

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Total Health Spine & Nutrition and staff who now or in the future treat me while employed by Total Health Spine & Nutrition.

I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions its content, and by signing below I agree to the above-named procedure. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____________________________________ ________________
Patient Signature Date Signed

____________________________________ ____________________________________ ________________
Guardian Name & Relationship to Patient Guardian Signature Date Signed

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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 Signature Date Signed

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize the doctor and whomever he/she may designate as assistance to administer chiropractic care as he/she deems necessary to my child.

____ ______________________
Signature of Parent or Guardian Date Signed

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I acknowledge that Total Health Spine & Nutrition's "Notice of Privacy Practices" published April 14, 2003 has been provided to me.

I understand I have a right to review Total Health Spine & Nutrition's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Total Health Spine & Nutrition.

The Notice of Privacy Practices for Total Health Spine & Nutrition is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Total Health Spine & Nutrition's duties with respect to my protected health information.

Total Health Spine & Nutrition reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing Total Health Spine & Nutrition's website.

I have the right to revoke this consent, in writing, except to the extent that Total Health Spine & Nutrition has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

______________________________ ______________

Patient Signature or Personal Representative Date Signed

____

Description of Personal Representative's Authority

PATIENT INFORMATION RELEASE AUTHORIZATION

I hereby authorize Total Health Spine & Nutrition to release information contained in my patient records to the individual(s) and only under the conditions listed below:

Name of person(s) to whom information can be disclosed to (i.e. spouse, family member, friend, another doctor, etc):

____

____

Specific type of information to be disclosed (i.e. all records, x-rays, blood tests, etc):

____

____

***PLEASE NOTE THAT THIS AUTHORIZATION RELEASE IS EFFECTIVE UNTIL WRITTEN NOTIFICATION IS RECEIVED BY OUR OFFICE REVOKING AND/OR CHANGING AUTHORIZATION**

______________________________ ______________

Patient Signature Date Signed

______________________________ ______________

Parent or Guradian Signature Date Signed

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Total Health Spine & Nutrition. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Total Health Spine & Nutrition responsible for any errors or omissions that I may have made in the completion of this form.

______________________________	____________________
Patient Signature	Date Signed
______________________________	____________________
Parent or Guardian Signature	Date Signed