New Patient Application - Adult

Full Name:_____ Today's Date:_____/___/____
Date of Birth:____/_____/____ Current Age:_____ Gender: Male____ Female_____
Home Address:_____
City, State, Zip:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____
Email: _____
Marital Status:_____# of Kids:_____
Occupation:_____

Emergency Contact:_____
Home Phone: _____ Cell Phone:_____

Do you have any health concerns for:
Spouse_____Kids_____
Family_____Friend_____

Who's your Medical Doctor or General Practitioner?_____

Do you have insurance you would like us to check on? □ Yes □ No (If yes, please show insurance card at front desk.)

How did you hear about our office?_____

This office deals with the health and well being of the individual and how the nervous system helps or hinders your body's expression of that health and well being. Our goals are, first, to address the issues that brought you to this office by improving your function, and second, to offer you the opportunity to participate in a program that will allow your body to express the full potential of health it was designed for. As a result, the following questions will help us to more accurately address your areas of health concern and allow us to accurately design a program to allow you to reach your maximum health potential.

Purpose For This Visit
Reason for this visit (Chief Complaint):_____
_____
_____
_____

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 paperwork.*
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:_____
_____

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 as 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?

Indicate all conditions you're experiencing now, or have in the past:
□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?

Indicate all conditions you're experiencing now, or have in the past:
□Heart Palpitations, □Recurrent Lung Infections/Bronchitis, □Heart Murmurs, □Asthma/ Wheezing, □Tachycardia, □Shortness Of Breath, □Heart Attacks/Angina, □Pain On Deep Inspiration/Expiration
Please explain:_____

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?

Indicate all conditions you're experiencing now, or have in the past:
□Mid Back Pain, □Nausea, □Diabetes, □Pain in Ribs/Chest, □Ulcers/Gastritis, □Hypoglycemia/Hyperglycemia, □Indigestion/Heartburn, □Reflux, □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?

Indicate all conditions you're experiencing now, or have in the past:

□Pain in hips/legs/feet, □Weakness/injuries in hips/knees/ankles, □Low back pain, □Numbness/tingling in legs/feet, □Recurrent bladder infections, □Coldness in legs/feet, □Frequent/difficulty urinating, □Muscle cramps in legs/feet, □Sexual dysfunction, □Constipation/Diarrhea, □Menstrual irregularities/cramping (females)

Please explain:_____

OTHER

Current dietary lifestyle: Do you follow any particular style or program of eating? □Yes □No
Explain._____

Current exercise lifestyle: Do you exercise regularly? □Yes □No
What type of exercise do you do? _____

Please check any of the following that you use: □Tobacco, □Alcohol, □Coffee, □Tea, □Carbonated Beverages, □Aspirin, □Tylenol, □Advil, □Antacids, □Recreational drugs.
Describe briefly._____

What other things do you do to promote your health?

_____

Who was the last doctor that helped you design a wellness program for your health?
Describe._____

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):

_____

_____

_____

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

Family Health History

Have any of your family members ever been diagnosed with the following? (Check 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:_____

Pregnancy Release (women)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his 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 my last menstrual cycle: _____

Patient's Signature_____ Date_____

Our Privacy Policy

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your information to:

* Treat you, Collect payment, Run our office, Do research, Inform you about other services, Discuss your case with family, Include you in care classes, Thank you for referring other patients.

We may use your health information for:

Health and safety reasons, Reporting to law officials, Reporting victims of abuse, Court hearings and filings, Reporting to worker's compensation.

You have the right to:

Request a copy of your health record, Request a list of whom we share your information, Ask us to limit the information we share, Advise our management if you believe your privacy rights have been violated, Request confidential communications, Amend your protected health information.

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises 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;

I, _____have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfactions.
I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child:
I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(signature) (date)

Pure Life
FAMILY WELLNESS

12850 Jones Rd, Suite 101
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