Patient Application For Treatment

TODAY'S DATE _____ ACCOUNT # _____

NAME _____ GENDER _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ MOBILE PHONE _____

MARITAL STATUS: S M D W NAME OF SPOUSE _____ # OF CHILDREN _____ AGES _____

EMAIL _____ HAS ANY MEMBER OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ☐ YES ☐ NO

OCCUPATION _____ EMPLOYER _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR? ☐ YES ☐ NO HOW LONG HAS IT BEEN? _____

SOCIAL SERCURITY # _____ - _____ - _____ WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF AN EMERGENCY: CONTACT _____ PHONE _____

DO YOU EXERCISE? ☐ YES ☐ NO HOW OFTEN? _____ TYPE? _____

HAVE YOU EVER SUFFERED OR BEEN DIANOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

Y	N	*Broken or Fractured Bones	Y	N	*Osteoarthritis	Y	N	Eating Disorder
Y	N	Circulatory Problems	Y	N	Epilepsy	Y	N	Alcoholism
Y	N	*Rheumatoid Arthritis	Y	N	Pacemaker	Y	N	Drug Addiction
Y	N	Seizures/Convulsions	Y	N	Strokes	Y	N	HIV Positive
Y	N	A Congenital Disease	Y	N	*Cancer	Y	N	Gall Bladder
Y	N	Excessive Bleeding	Y	N	Ulcers	Y	N	*Head Problems
Y	N	High/Low Blood Pressure	Y	N	Ruptures	Y	N	Depression
Y	N	*Diabetes	Y	N	Coughing Blood	Y	N	Tumors

*Explanation _____

_____

_____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

NAME OF YOUR FAMILY DOCTOR _____ PHONE _____

ADDRESS _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

_____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING? ☐ Cancer ☐ Diabetes

☐ Tuberculosis ☐ Heart Condition ☐ If yes, please explain: _____

_____

For Doctor's Use Only

☐ **General**

Injury Type:

Drug Allergies:

☐ **See Meds Addendum**

DATE _____

ACCT _____

PATIENT _____

System Review

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

High Blood Pressure _____
Dizziness/Fainting _____
Insomnia _____
Low Resistance _____
Tension _____
Confusion _____
Fatigue _____
Ulcers _____
Eye/Vision Problems _____
Ear/Hearing Problems _____
Difficulty Breathing _____
Heart Problems _____
Loss of Bladder Control _____
Constipation _____
Diarrhea _____
Digestion Problems _____
Nausea _____
Female Problems _____
Prostate Problems _____
Diabetes _____
Hands/Feet Cold _____
Hand Tremors _____
Loss of Memory _____
Nervousness _____
Sweaty Palms _____
Speech Difficulty _____
Anxiety _____
Depression _____
Irritability _____

For Doctor's Use Only

DR.

REVIEWED SYSTEMS	SYMPTOMS
_____ General	Weight changes, fatigue, anorexia, weakness, fever, chills, changes in activity.
_____ Skin	Rashes, Eruptions, changes in warts or moles, pigmentation changes, bruising, itching hair loss, nail changes.
_____ Head	Trauma, headaches, dizziness, light headed
_____ Eyes	Change in acuity of vision, use of corrective lenses, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimination, redness, discharge
_____ Nose	Rhinorrhea, expistaxis, allergies, airway obstruction.
_____ Mouth& Throat	Ulcers, tooth pain, extractions, temporomandibular joint (TMJ) pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat.
_____ Neck	Stiffness, lumps, swelling, masses, pain
_____ Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats.
_____ Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope.
_____ Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever.
_____ Breasts	Self-examination, frequency, results, pain, nipple discharge, lumps, masses, skin dimpling.
_____ Gastrointestinal	Unusual diet, dysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, constipation, change in bowel habits, jaundice, abdominal swelling.
_____ Genitournary	Polyuria, nocturia, oliguria, dysuria, urgency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia.
_____ Endocrine	Polydipsia, polphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstruation, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric.
_____ Hematopoietic	Anemia, abdominal bleeding, lymph node enlargement/pain
_____ Musculoskeletal	Bone, joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy.
_____ Neurological	Cranial Nerve defects, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia.
_____ Psychological	Mood swings, depression, anxiety, phobias.

Problem/ Medication List

Dr.Name/Facility	Problem	Type of Treatment	From When to When?	Name of Medication/Vitamin	Who Prescribed Dr / Self

HIPAA
Notices of Privacy Practices
Performance Spine & Sport

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (847) 208-5738.

Complaints – Complaints about your privacy rights, or how our office has handled your health information should be directed to our Compliance Officer by calling (847) 208-5738. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (847) 208-5738

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Patient Name Date

_____

Patient/Guardians Signature

Date _____

Acct _____

Patient _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

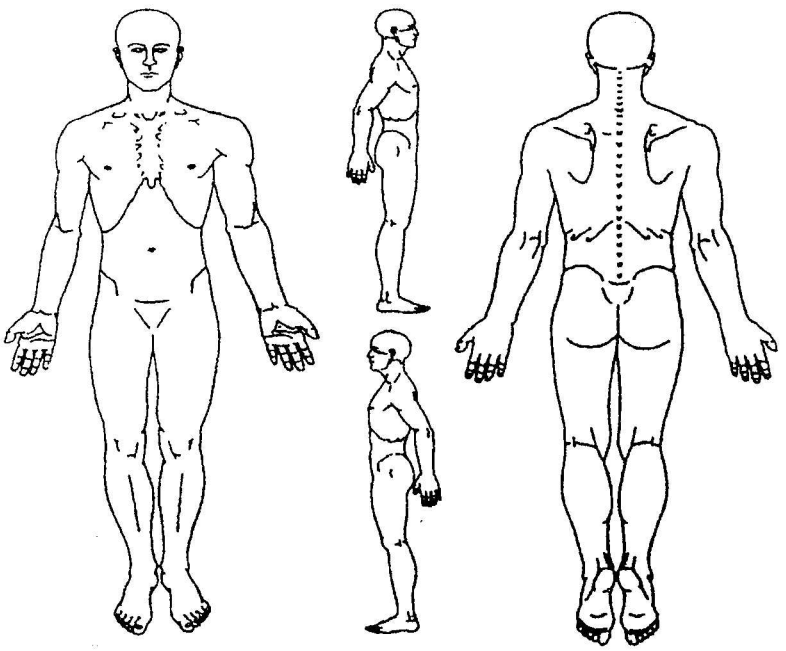
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below, please **circle** the **percentage of time** you experienced your **main complaint**:

		Occasional			*Intermittent*			*Frequent*		*Constant*
0	10	20	30	40	50	60	70	80	90	10

4. How long have you been experiencing your **main complaint**?_____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ☐ AM ☐ PM How long does it last?_____ Mins_____Hrs
7. What makes it feel better?_____
8. What makes it feel worst? _____
9. Have you ever had this problem in the past? ☐ Yes ☐ No
10. I have ☐ Be hospitalized ☐ Been treated by another chiropractor ☐ Been treated by another specialty provider ☐ Never received care for this problem.
11. Have you lost time from work because of it? ☐ Yes ☐ No Dates? _____To_____
12. Are you pregnant? ☐ Yes ☐ No
13. What was the first day of your last menstrual cycle?_____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/or difficulty performing any of the following activities: (Check)

_____Personal Care_____ Lifting_____ Reading_____ Concentrating_____Work_____ Driving_____ Sleeping

_____ Recreation _____ Walking_____ Sitting_____ Standing_____ Social Life

Patient Signature _____ **Date** _____

PERFORMANCE
Spine & Sport

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Myotherapy

Any myotherapy performed as part of your ongoing treatment protocol is only to be done as and when prescribed by the doctor. Myotherapy is a combination of deep tissue manual therapy, trigger point reduction, therapeutic exercise to stretch the muscles and neuromuscular therapy.

Our Myotherapists are trained to work with the doctor in aiding your recovery. The doctor at Performance Spine & Sport utilizes a unique approach of combining chiropractic, physiotherapy and myotherapy in order to expedite your healing process and maintain your progress. Both physical therapy and myotherapy, as prescribed by the doctor, are imperative to the progress and treatment discussed with the doctor.

Please read the following and sign the bottom of the form.

1. I understand that myotherapy may be part of my treatment protocol and when the therapists are performing therapies in accordance to my treatment plan, they may NOT accept gratuities. (They thank you for the thought)
****This does not apply when a 30/60 min massage is purchased.****

2. Performance Spine & Sport's myotherapists have been trained by management to maintain the highest level of professionalism. Due to specific procedures considered acceptable, there will be no unapproved therapies. (i.e. Hot Stone, Swedish Massage, or inappropriate behavior by patients)

It's the intention of the Performance Spine & Sport to provide you with the most effective treatment for your condition and the combination of Chiropractic adjustments, physiotherapy, strengthening, stretching, and myotherapy.

I have read the above and understand the purpose of myotherapy is for its therapeutic value. I also understand that I must treat the therapist with the utmost professionalism as they will treat me, and that they may not accept gratuities. I am aware that if myotherapy is part of my care plan as well as physical therapy and chiropractic manipulations, I must follow the doctor's treatment plan accordingly, without leaving out any part of treatment or strictly taking advantage of myotherapy only.

_____ _____
Printed Name Date

_____
Signature

PERFORMANCE
Spine & Sport

Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal, to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statement.
(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

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.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her staff have my permission to perform an x-ray evaluation. I understand that x-rays can be hazardous to an unborn child.

_____ _____
Signature Date