Date: _____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone:_____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an **auto accident** / **work injury**? □ Yes □ No If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin? _____/_____/_____ When did you first notice it? _____

Is this condition getting worse? □ Yes □ No Is this condition: □ Constant □ Comes & goes □ Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? □ Yes □ No Describe:_____

Have you experienced this condition before? □ Yes □ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you Feel/respond? _____

Family Physician and/or referring Physician's name and number _____

EXPERIENCE WITH CHIROPRACTIC or PHYSICAL THERAPY

Have you seen a Chiropractor or Physical Therapist before? □ Yes □ No Who? _____ When? _____

Reason for prior visit: _____

How did you respond to care? _____

Did your previous Doctor of Chiropractic take before and after x-rays? □ Yes □ No

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

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

Are you aware of any poor posture habits in your spouse or 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 felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? [ ] YES [ ] NO

HEALTH LIFESTYLE

Do you exercise? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? [] Running [] Jogging [] Weight Training [] Cycling [] Yoga [] Pilates [] Swimming [] Other _____

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much / week? _____

Do you drink coffee? [ ] Yes [ ] No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

Please list any medications you are currently taking: _____

_____

Please list any health conditions not mentioned: _____

Please list any significant family history: _____

_____

Please list any surgeries: _____

Have you ever tested HIV positive: [] YES [] NO

AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical 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 will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care 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 Doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physical therapist for all services rendered.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's signature	Date

_____	_____	_____
Minor's Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

HEALTH INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work-related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that my insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patient Signature: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____

I hereby authorize Complete Wellness Chiropractic to administer care deemed necessary to my child or spouse, a minor under the age of 18 years old.

RADIOGRAPH CONSENT FORM

I _____ do hereby give my consent to allow Complete Wellness Chiropractic and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient or Guardian of Minor/Child_____ Date _____

HIPPA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES **COMPLETE WELLNESS CHIROPRACTIC** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Complete Wellness Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Complete Wellness Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor or Therapist in private, the Doctor or Therapist will provide a private room for these conversations.

By signing the following you are giving Complete Wellness Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

IN CASE OF EMERGENCY CALL:

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____