File #: ______

Inner Health Chiropractic

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 is by specific adjustments of 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 interference with nerve transmission which alters nerve function, resulting in a lessening of the body's innate ability to express it's maximum health potential.

Our Primary Practice Objective is to eliminate major interferences to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you and finding the cause of your problem.

______________________________ ______________________________

Patients Signature Date

File #: ______

INNER HEALTH CHIROPRACTIC

Confidential Patient Information

Patient Name: ____

Email Address: _________________________ **Facebook: Y or N** if yes, please give us your e-mail to add you.

Address: ______________________________ City: _____________ State: ________ Zip: ________

Home Phone: ____________________ Cell: ___________________ Work: __________________

Social Security#: ___________________ DOB: ____/____/____ Age: ______ Sex: M / F Marital Status: ________

Patients Employer: _________________________________ Occupation: ____________________

Employer Address: ________________________ City: _____________ State: ________ Zip: ________

Emergency Contact: ____________________ Phone #: _____________ Relationship to Patient: __________

Referred By: ____

Insurance Information: (Insurance Holder Information)

Insured Name: ____________________________ Insured DOB ____/____/____ SS#: _________________

Relationship to Patient: ___________________ Insured ID #: _______________ Group #: _____________

Insurance Company: ________________________ Address: ____________________________________

Auto Accident Information:

Date of Accident: ____/____/____ Was the accident reported to the at fault or not at fault insurance company? YES NO

At Fault Information: Insurance Company: __________________ Phone #: ____________ Claim #: _________

Attorney Name: ____________________ Address: _______________________ Phone #: ____________

Work Related Accident:

Was this accident reported to your employer? YES NO Date of Injury: ____/____/____ BWC Claim #: _____________

Attorney Name: ____________________ Address: _______________________ Phone #: ____________

Treatment of a Minor

I, _________________________, give my permission to Inner Health Chiropractic and its representatives to render the necessary treatment to my child, ___________________________.

Parent/Guardian Signature: _______________________ Phone #: _______________ Date: ____________

Authorization for Assignment of Benefits/Information Release:

I authorize payment of medical insurance benefits to Inner Health Chiropractic for any services furnished to me. I also authorize you to release medical information concerning my health care to any attorney, insurance company, or third-party payors, and/or their respective agent(s). This information will be used for the purpose of evaluation and administering claim benefits.

Patients Signature: ____ Date: ____________________

File #: ______

PURPOSE OF THIS VISIT

What is your Main Health Concern? ___________________________

When did this concern begin? ____/____/____

Did it begin: Gradual Sudden Progressive over time

Is this concern related to an auto accident / work injury? Yes No

What activities aggravate your symptoms? ____________________

____

Is there anything, which has relieved your symptoms? Yes No

Describe: ____

Is this condition getting worse? Yes No

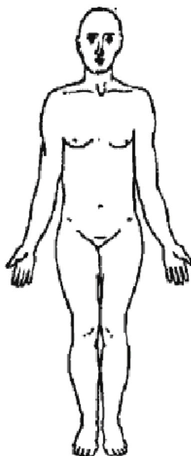
How often do you experience these symptoms throughout the day?

100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with:

__ Work __ Sleep __ Hobbies __ Daily Routine

Explain: ____



SEVERITY OF PAIN

List region of pain and circle severity number. (1 = least, 10 = greatest)

MARK PAIN REGION

Burning • Stabbing • Sharp • Constant

ex. Neck ______________ *Sharp*

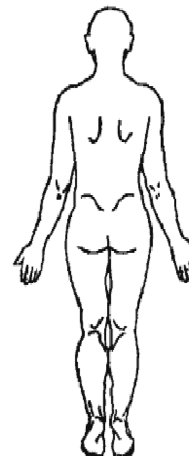
1 2 3 4 5 6 (7) 8 9 10

MARK PAIN AREA

+++ Burning
000 Stabbing
- - - Sharp
| | | Constant
XXX Other

REGIONS

Region	Severity
Neck	1 2 3 4 5 6 7 8 9 10
Mid Back	1 2 3 4 5 6 7 8 9 10
Low Back	1 2 3 4 5 6 7 8 9 10
Hips	1 2 3 4 5 6 7 8 9 10
Arms	1 2 3 4 5 6 7 8 9 10
Legs	1 2 3 4 5 6 7 8 9 10



Please mark area of pain/discomfort on the drawing using code listed above.

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 respond? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? ______________ When? ______________

Reason for visits: ____

How did you respond? ____

Did your previous chiropractor 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: ______________

Would you like to loss weight? Yes No

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)? Yes No What? ______________________

Are you interested in taking supplements (i.e. vitamins, minerals, herbs)? Yes No

File #: ______

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).
Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

__ Neck Pain
__ Pain into your shoulders/arms/hands
__ Numbness/tingling in arms/hands
__ Hearing disturbances
__ Weakness in grip
__ Headaches
__ Dizziness
__ Visual disturbances
__ Coldness in hands
__ Thyroid conditions
__ Sinusitis
__ Allergies/Hay fever
__ Recurrent colds/Flue
__ Low Energy/Fatigue
__ TMJ/Pain/Clicking

Explain: ____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

__ Heart Palpitations
__ Heart Murmurs
__ Tachycardia
__ Heart Attacks/Angina
__ Recurrent Lung Infections/Bronchitis
__ Asthma/Wheezing
__ Shortness Of Breath
__ Pain On Deep Inspiration/Expiration

Explain: ____

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

__ Mid Back Pain
__ Pain Into Your Ribs/Chest
__ Indigestion/Heartburn
__ Reflux
__ Nausea
__ Ulcers/Gastritis
__ Hypoglycemia
__ Tired/Irritable after eating or when you haven't eaten for a while

Explain: ____

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

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

Explain: ____

Please list any health conditions not mentioned: ________________________________

Please list any medications currently taking and their purpose: ________________________________

Please list all past surgeries: ________________________________

Please list all previous accidents and falls: ________________________________

File #: ______

Inner Health Chiropractic

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I understand your **Notice of Privacy Practices** contain a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time to obtain a current copy of the **Notice of Private Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

By signing below I would like to give the following people permission to have access to my health records:

Name____ Relationship_____________________________________

Name____ Relationship_____________________________________

Patient/Guardian Name: ____

Signature: ______________________________________ Date: ___________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this ***Notice of Privacy Practices Acknowledgement***, but was unable to do so as documented below:

Date:________Initials:_____