

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: **M** **F**
Home Address: _____ Home Phone: () _____
City, State, Zip: _____ Work Phone: () _____
Email Address: _____ Cell Phone: () _____
Birth Date: ____/____/____ Marital Status: **S** **M** **D** **W**
Names of Children: _____ Ages: _____
Occupation: _____ Employer Name: _____
Spouse's Name: _____ Cell Phone: () _____ Work 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 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 fell 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** _____ 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)? _____

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...?

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flue |
| <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> 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...?

- | | |
|---|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain on Deep Inspiration/Expiration |

THORACIC 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...?

- | | |
|--|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into Your Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |

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...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections | |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating | |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) | |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sexual dysfunction | |

Please list any health conditions not mentioned: _____

Please list any medications / surgeries: _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Gall bladder |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Smallpox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Other: _____ | | | |

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use 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 and/or physical therapist 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 doctors and/or physical therapist 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

Minors Name

Guardian/Spouse's Signature of Authorizing care for minor

Date

IN CASE OF EMERGENCY

Name _____

Relationship _____

Work Phone _____

Home Phone _____

Cell Phone _____

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES Denver Integrated Spine Center TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Denver Integrated Spine Center, 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 Denver Integrated Spine Center, 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 physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Denver Integrated Spine Center, 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