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Application for Care at
ESSENTIAL CHIROPRACTIC

Today's Date: ____________________ HRN: __________

PATIENT DEMOGRAPHICS

Name: ____________________ Birth Date: ___-___-_____ Age: _____ ☐ Male ☐ Female

Address: ____________________ City: __________ State: ___ ZIP: _____

Email: ____________________ Home Phone: __________ Mobile Phone: __________

Marital Status: ☐ Married ☐ Single Do You Have Insurance? ☐ Yes ☐ No Work Phone: __________

Social Security Number: ____________________ Driver's License Number: ____________________

Employer: ____________________ Occupation: ____________________

Spouse's Name: ____________________ Spouse's Employer: ____________________

Number of Children and Ages: ____________________

Name and Number of Emergency Contact: ____________________ Relationship: __________

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office:

Primarily:	Second:	Third:	Fourth:

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is:	1	2	3	4	5	6	7	8	9	10
Second complaints is:	1	2	3	4	5	6	7	8	9	10
Third complaints is:	1	2	3	4	5	6	7	8	9	10
Fourth complaints is:	1	2	3	4	5	6	7	8	9	10

When did the problem begin? __________ When is the problem at it's worst? ☐ AM ☐ PM ☐ Mid-Day ☐ Late PM

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ it comes and goes throughout the week

How did the injury happen? ____________________

Condition(s) ever been treated by anyone in the past? ☐ Yes ☐ No If yes, when? __________ By whom? __________

How long were you under care? __________ What were the results? ____________________

Name of Previous Chiropractor: ____________________

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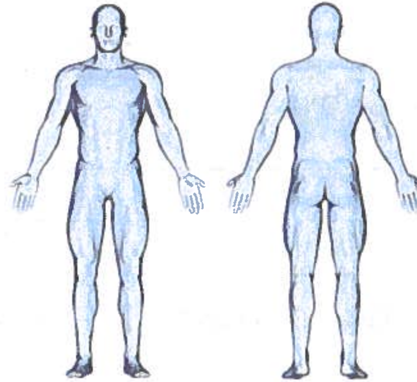
PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:	
R = Radiating	**B** = Burning
D = Dull	**A** = Aching
N = Numbness	**S** = Sharp/ Stabbing
T= Tingling	



What releives your symptoms? ______

What makes them feel worse? ______

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL:	USUAL ACTIVITY LEVEL:
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

______

______

______

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No If yes, how many times? ______

When was the last episode? ______ How did the injury happen? ______

Other forms of treatment tried? ☐ Yes ☐ No If yes, please state what type of treatment: ______

Who provided it: ______ How long ago? ______ What were the results? ☐ Favorable ☐ Unfavorable

Please Explain: ______

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

______

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the **Past**, C for **Currently Have** and N for **Never Have Had**:

___ Broken Bone ___ Heart Attack ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Dislocations ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions

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	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DESEASES			
ADULT DESEASES			

SOCIAL HISTORY

1. Smoking ☐ Cigars ☐ Pipes ☐ Cigarettes

How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcholic beverage consumption ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational drug use ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime:
How does your present problem affect the following, See page 2- Activities of Life

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes

If yes, whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Daughter(s) ☐ Son(s)

Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes ______________________

I hereby authorize payment to be made directly to ESSENTIAL CHIROPRACTIC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ESSENTIAL CHIROPRACTIC for any and all services I receive at this office.

______________________________ ___-___-_____
Patient or Authorized Person's Signature Date Completed

______________________________ ___-___-_____
Doctor's Signature Date Form Reviewed

Patient's Name: ________________ HR#: ________________ ___/___/___ JDD,DC 5/2011

Patient Name_______________________________ File#/HRN ___________ Date__________

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ____

What speed was the collision? ____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe ____

When was your most recent strain / stress at work? ____

Please describe the manner of the injury ____

Was treatment received? Please describe ____

Does your job require you remain in long term stressful postures?____________________

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? ____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values?________

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _______

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

____

____

____

INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____________What is your current weight? ___________

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) ________

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Doctor Signature ________________________________Date__________________JDD, DC 5/2011

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Activities of Daily Living/Symptoms/Medications

Patient Name: ______________________ Date: ______________ File#__________

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity				
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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Please mark P for in the Past, C for Currently have and N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Heartburn
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Digestive Problems	___ Digestive Problems
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Colon Trouble	___ High Blood Pressure
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Menopausal Problems	___ Asthma
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menstrual Problem	___ Difficulty Breathing
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ PMS	___ Lung Problems
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ Bed Wetting	___ Kidney Trouble
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Learning Disability	___ Gall Bladder Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Trouble Sleeping	___ Hepatitis (A,B,C)
___ Impotence/Sexual Dysfunction		___ Allergies	___ Ulcers	

List Prescription & Non-Prescription drugs you take:____

____

____

QUADRUPLE VISUAL ANALOGUE SCALE

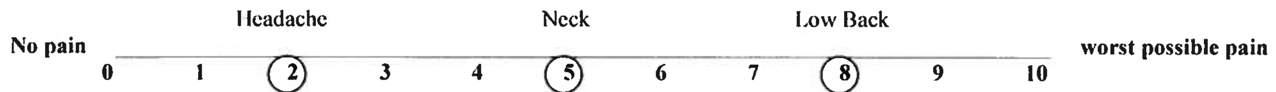
Patient Name ______________________________ Date ________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

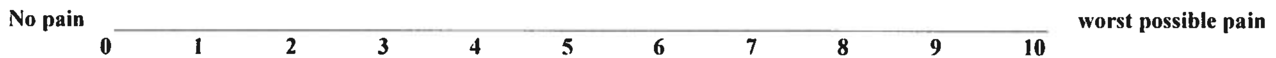
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

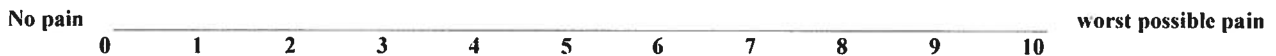


1 – What is your pain RIGHT NOW?

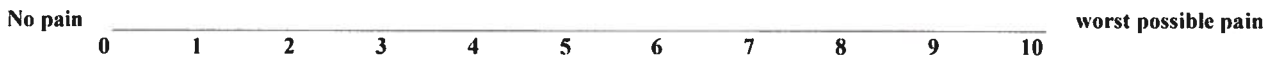
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Essential Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_______________________________________ ____/____/____ Witness Initials
Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_______________________________________ ____/____/____ Witness Initials
Patient or Authorized person's Signature Date

Administrative Notice of Office Policies

OUR OFFICE POLICIES

Welcome to Essential Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Essential Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to diversified and pettibon techniques. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

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Note: Patient retains the above Notice of Office Policies and **ESSENTIAL CHIROPRACTIC** retains the signature sheet.

Patient initials:__________-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_______________________________   _____________   ___________

Patient's Name   DOB   HR#

_______________________________   _____________

Patient signature   Date

_______________________________   _____________

Witness   Date

JDD,DC 5/2011

Essential Chiropractic

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or the general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:
If you wish to make a formal complaint about how we handle your health information, please call Beatrice Todorut at 239-300-0885. If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

JDD,DC 5/2011

Patient initials: __________

Essential Chiropractic's

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

I have received a copy of **Essential Chiropractic's** Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies are kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

______________________________ ____________ ____________

Patient's Name DOB HR#

______________________________ ____________

Patient signature Date

______________________________ ____________

Witness Date