PRO HEALTH
CHIROPRACTIC CENTER

WELCOME TO OUR OFFICE!

We specialize in assisting patients to achieve their highest level of health through the 5 Essentials of health. Our healthcare delivery system is very unique and advanced compared to other healthcare programs. This allows our patients to achieve far superior results in a shorter period of time.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. If you need any assistance, please feel free to ask any questions.

We look forward to serving you.

Signature_____

Today's Date_____

PATIENT APPLICATION FORM

Name_____ Age_____ DOB____/____/_____ ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

Employer_____ Occupation_____

Marital Status ☐ S ☐ M ☐ D ☐ W Spouse's Name_____

Names & Ages of Children_____

Spouse's Employer_____ Spouse's Occupation_____

How were you referred to this office?_____

LIFE GOALS

What are your life goals and where do you see yourself in the next 10 to 20 years?

1. _____

_____

2. _____

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3. _____

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4. _____

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5. _____

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6. _____

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7. _____

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8. _____

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Signature_____ Today's Date_____

PURPOSE OF THIS VISIT

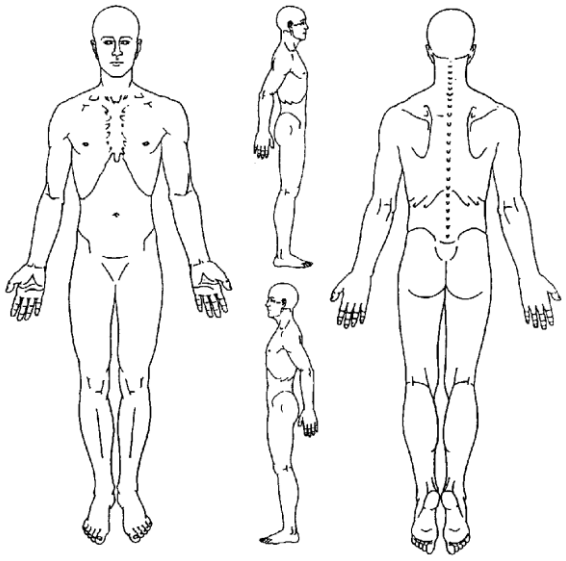
Identify the condition(s) that brought you to our office.

Primary_____ Secondary_____

Tertiary_____ Quaternary_____

Rate the severity of the above complaint(s) on a scale of 0-10.

Primary	0	1	2	3	4	5	6	7	8	9	10
Secondary	0	1	2	3	4	5	6	7	8	9	10
Tertiary	0	1	2	3	4	5	6	7	8	9	10
Quaternary	0	1	2	3	4	5	6	7	8	9	10



Fill in <u>all</u> areas of discomfort on the figure to the right by using the following letters: **A** – aching **B** – burning **D** – dull **N** – numbness **R** – radiating **S** – sharp **T** – tingling

When did this problem begin_____ Has it ever occurred before ☐ Yes ☐ No

How did the problem begin ☐ Gradual ☐ Sudden ☐ Progressive over time, what period_____

The problem is worse in ☐ AM ☐ PM ☐ At Night ☐ With Activity (bending, lifting, sitting, standing)

Frequency of complaint is ☐ Constant ☐ On/off during day ☐ Comes and goes throughout the week

Is condition related to ☐ Auto Accident ☐ Work Injury ☐ No Injury ☐ Other_____

What makes you feel better_____ What makes you feel worse_____

How often do you experience these symptoms throughout the day ☐ 100% ☐ 75% ☐ 50% ☐ 25%

Does complaint(s) interfere with ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine

EXPERIENCE WITH CHIROPRACTIC

Have you ever received chiropractic care ☐ No ☐ Yes, Dr. Name_____ Last visit_____

Reason for visits_____

How did you respond_____

Did your previous chiropractor take before and after x-rays ☐ No ☐ Yes, results_____

Did you know that posture determines your health ☐ No ☐ Yes

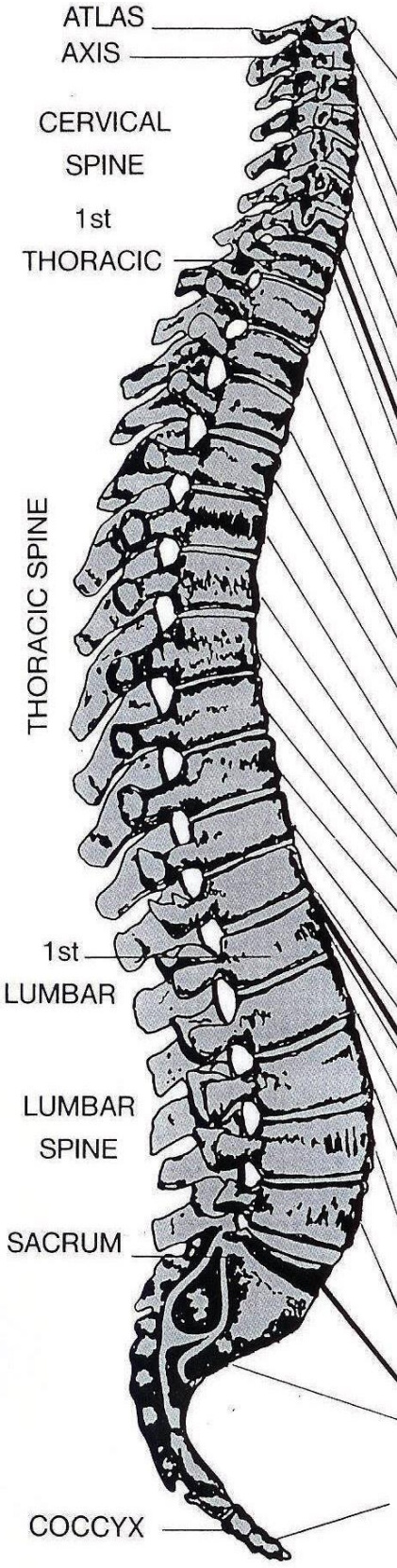
Are you aware of any of your poor posture habits ☐ No ☐ Yes, explain_____

Have you had any spinal traumas in the past ☐ No ☐ Yes, explain_____

Have you ever noticed or been told that you ☐ Carry your head forward

☐ Have rounding of your shoulders ☐ Have a “hump” at the base of your neck

Place a check in the appropriate box under the "Possible Effects" column to indicate your symptoms.



Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.	☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
4C	Nose, lips, mouth, eustachian tube.	☐hay fever,☐runny nose,☐hearing loss,☐adenoids.
5C	Vocal cords, neck glands, pharynx.	☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.
6C	Neck muscles, shoulders, tonsils.	☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.
7C	Thyroid gland, bursae in the shoulders, elbows.	☐ bursitis, ☐ colds, ☐ thyroid conditions.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.
2T	Heart, including its valves and covering; coronary arteries.	☐ functional heart conditions and certain chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.	☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
4T	Gall bladder, common duct.	☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
5T	Liver, solar plexus, circulation (general).	☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.
6T	Stomach.	☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
7T	Pancreas, duodenum.	☐ ulcers, ☐ gastritis.
8T	Spleen.	☐ lowered resistance.
9T	Adrenal and supra-renal glands.	☐ allergies, ☐ hives.
10T	Kidneys.	☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
11T	Kidneys, ureters.	☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.
12T	Small intestines, lymph circulation.	☐rheumatism,☐gas pains, ☐certain types of sterility.
1L	Large intestines, inguinal rings.	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.
2L	Appendix, abdomen, upper leg.	☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.
3L	Sex organs, uterus, bladder, knees.	☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.	☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
5L	Lower legs, ankles, feet.	☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
SACRUM	Hip bones, buttocks.	☐ sacro-iliac conditions, ☐ spinal curvatures.
COCCYX	Rectum, anus.	☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

NECK REGION

MID-BACK

LOW BACK

PELVIS

ACTIVITIES OF DAILY LIVING

What kind of effect does your condition(s) have on the following? Check **all** that apply.

Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Exercising	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting / Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

HEALTH LIFESTYLE

Do you take time to pray, meditate, or visualize on a regular basis ☐ No ☐ Yes, how frequent_____

Do you feel like you give enough attention to important areas in your life like spiritual life, family time, hobbies and personal growth ☐ Yes ☐ No, specify_____

Do you often feel short on time and procrastinate on projects ☐ No ☐ Yes, how frequent_____

Do you get an average of 8 hours of sleep per night ☐ Yes ☐ No, how many hours_____

Do you eat breakfast daily ☐ Yes ☐ No, why not_____

How many days per week do you skip at least one meal ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

How many fast food or pre-made meals do you eat weekly ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

How many servings of fruit do you have on a given day ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

How many servings of vegetables do you have on a given day ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Do you regularly consume 1+ of the following beverages per day? Check **all** that apply.

☐ Alcohol ☐ Coffee ☐ Diet Soda ☐ Juice ☐ Milk ☐ Soda ☐ Other_____

How many times per week do you exercise ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Type of exercise ☐ Cardio ☐ CrossFit ☐ Cycling ☐ Jogging ☐ MaxT3 ☐ Pilates
☐ Rowing ☐ Running ☐ Swimming ☐ Weights ☐ Yoga ☐ Other_____

What is your target weight_____ What is your current weight_____

Are you regularly exposed to cleaning products or industrial chemicals ☐ No ☐ Yes_____

Have you noticed mold growing at home, work, school, or car ☐ No ☐ Yes_____

Have you received a standard profile of vaccinations ☐ No ☐ Yes_____

Do you receive yearly flu shots ☐ No ☐ Yes, for how many years_____ reason why_____

Do you have symptoms of hormonal imbalance (thyroid, adrenal, etc.) ☐ No ☐ Yes_____

Do you ever take pills to go to sleep or to be able to relax ☐ No ☐ Yes, how frequent_____

Do you take any supplements ☐ No ☐ Yes, list all_____

List **all** medications you currently use, the condition or reason for use, and the length of time on medication.

_____

_____

_____

Check surgeries or procedures you've had and write the year. ☐ I've never had any surgeries/procedures

☐ Appendix ☐ C-Section ☐ Chemotherapy ☐ Gall Bladder ☐ Heart
☐ Hernia ☐ Reproductive ☐ Spine ☐ Thyroid ☐ Vaccinations

Other surgeries, procedures, or diseases not previously mentioned_____

FAMILY HISTORY	Cancer	Diabetes	Heart	Lung	Spine	Other disease
Mother	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Father	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____
Siblings	☐_____	☐_____	☐_____	☐_____	☐_____	☐_____

On a scale of 1 to 10 with 10 being the highest, what is your commitment to maximizing your health_____

Please specify any concerns that could interfere with your commitment (example: time, transportation, other)

_____

Do you have Health Insurance? ☐ No (many of our patients do not) ☐ Yes (please complete the box below)

Insured's Name_____ DOB____/____/____ SSN_____-____-_____

Insurance Company_____ Policy Number_____

TERMS OF ACCEPTANCE

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 understands 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 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 a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to PROHealth Chiropractic Center for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of PROHealth Chiropractic Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment including, but not limited to fracture, disk injury, stroke, dislocation and sprain/strain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. 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 treated 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 the programs offered, and that if I terminate my care prematurely all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature_____ Date_____

PREGNANCY RELEASE

Date of last menses_____. This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to a fetus.

Signature_____ Date_____

CONSENT TO X-RAY

By my signature below I am acknowledging that I have had the opportunity to discuss any risks associated with exposure to x-rays. After consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature_____ Date_____

CONSENT TO EVALUATE & ADJUST A MINOR

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.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES (HIPAA)

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

I authorize PROHealth Chiropractic Center and it's agents to give information regarding my treatment at PROHealth Chiropractic Center to family members, work associates or others over the telephone. I also authorized PROHealth Chiropractic Center, LLC and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I hereby acknowledge that I have been provided with the opportunity to review a Notice of Privacy Practices that provides a complete description of information uses and disclosures. This page is recognized by me as the signature page and will be retained by PROHealth Chiropractic Center as evidence of my receiving and understanding this notice. I further acknowledge that any concerns regarding these policies, as well as all of my questions, have been answered by a member of the staff to my complete satisfaction.

Signature_____ Date_____

If not signed by the patient, please indicate relationship.

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

Patient Name_____

FOR OFFICE USE ONLY

Signed form received by_____ Date_____

☐ Acknowledgement refused: efforts to obtain and reasons for refusal

_____

_____

_____