PATIENT APPLICATION FORM

We specialize in helping our patients 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.

Please fill out the following information thoroughly so the doctor can determine 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.

Patient Signature: _____

Patient Name: _____

Date: _____

PATIENT APPLICATION SURVEY

Full Name_____ Today's Date _____

Date of Birth_____Age_____ Gender F M Marital Status S M W D

Email _____ Social Security (Optional) _____

Address_____ City_____Zip_____

Home Phone_____ Cell Phone _____

Preferred Method Of Contact _____Occupation_____Employer_____

Emergency Contact/Relationship_____Emergency Phone _____

Who Should We Thank for Referring You to Foundation Spine & Posture? _____

PURPOSE OF THIS VISIT

Health Issue	Date Condition Started/How	Frequency	Severity (0-10)
1			
2			
3			
4			
5			
6			

Are these conditions getting worse? ❑ Yes ❑ No Is this: ❑ Constant ❑ Frequent ❑ Occasional ❑ Activity Related

How would you describe your pain / discomfort (check all that apply)

❑ Dull ❑ Achy ❑ Throbbing ❑ Stiff ❑ Sharp ❑ Stabbing ❑ Shooting

❑ Intense ❑ Burning ❑ Constricting ❑ Other (please describe) _____

Does your condition interfere with:

❑ Work ❑ Sleep ❑ Hobbies ❑ Daily Routine (please describe) _____

What activities aggravate your symptoms?

❑ Coughing ❑ Sneezing ❑ Bearing Down ❑ Lifting ❑ Bending ❑ Pushing ❑ Pulling

❑ Driving ❑ Sitting ❑ Walking ❑ Running ❑ Standing ❑ Laying Down ❑ Movement

Other:_____

Is there anything that has relieved your symptoms? ❑ Yes ❑ No

❑ Ice ❑ Heat ❑ Massage ❑ Resting ❑ Exercise ❑ Sitting ❑ Standing

❑ Bracing/Taping ❑ Stretching ❑ 'Popping' Joints ❑ Lying ❑ Other _____

PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? ❑ Yes ❑ No If yes, where? _____

Do you experience numbness and tingling anywhere? ❑ Yes ❑ No If yes, where? _____

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

Please Explain:

Are you aware of poor posture habits in your spouse or children? ❑ Yes ❑ No

Please 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 effects 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/Walking ❑ Weight Training ❑ Cycling ❑ Yoga/Pilates ❑ Other: _____

Do you smoke? ❑ Yes ❑ No How much? _____

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

Do you drink caffeine? Yes ❑ Yes ❑ No How many/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/shifted 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 can have many serious and adverse effects 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). On the next page, please check any health conditions you may be experiencing, now or in the past.

HEALTH LIFESTYLE (continued)

CERVICAL SPINE (NECK)

Postural distortions from subluxations in your neck can weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

- ❑ Neck Pain
- ❑ Headaches/Migraines
- ❑ Allergies/hay fever
- ❑ Recurrent colds/flu
- ❑ Immune system weakness
- ❑ Whiplash
- ❑ Pain into your shoulders /arms/hands
- ❑ Thyroid Conditions
- ❑ Sinusitis
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Forgetfulness/memory loss
- ❑ Numbness/tingling in arms/hands
- ❑ TMJ/Pain/Clicking
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ ADHD/difficulty focusing
- ❑ Brain Fog
- ❑ General Fatigue
- ❑ Insomnia /sleep disorders
- ❑ Low Metabolism
- ❑ Difficulty Losing Weight
- ❑ Anxiety / Depression
- ❑ Skin Issues -Acne, Dry

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations in the upper back can weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

- ❑ Heart palpitation
- ❑ Tachycardia
- ❑ Recurrent lung infections/bronchitis
- ❑ Persistent cough
- ❑ Heart murmurs
- ❑ Shortness of breath
- ❑ Asthma/ wheezing
- ❑ Heart attacks/angina
- ❑ Pain on deep inhalation / exhalation

THORACIC SPINE (MID BACK)

Postural distortions from subluxations in the mid back can 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
- ❑ Acid reflux
- ❑ Nausea
- ❑ Ulcers/gastritis
- ❑ Tired/irritable after eating or when you haven't eaten
- ❑ Indigestion/heartburn
- ❑ Hypoglycemia

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in the low back can weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience:

- ❑ Low back pain
- ❑ 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
- ❑ Gassiness/bloating
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infection
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction

Please list any health conditions not mentioned: _____

MEDICAL HISTORY

Have you or anyone in your family been diagnosed with any of the following:

❑ Diabetes / Neuropathy	❑ Varicose Veins	❑ Neurological Problems	❑ Lung Disease
❑ Rheumatic Fever	❑ Circulatory Problems	❑ Stroke	❑ Heart Murmurs
❑ High Blood Pressure	❑ Heart Disease	❑ Cancer	❑ Osteoporosis
❑ Kidney Disease	❑ Seizures	❑ Migraine	❑ Headaches
❑ Liver Disease	❑ Metal Implants	❑ Infectious Disease	❑ Gallbladder
❑ Broken Bones/Fractures	❑ Appendectomy	❑ Tonsillectomy	❑ Hernia
❑ Pneumonia	❑ Polio	❑ Tuberculosis	❑ Anemia
❑ Whooping Cough	❑ Chicken pox	❑ Mumps	❑ Measles
❑ Thyroid	❑ Small Pox	❑ Influenza	❑ Pleurisy
❑ Arthritis	❑ Epilepsy	❑ Difficulty Urinating	❑ Eczema
❑ Gout	❑ Prostate	❑ Glaucoma	❑ AIDS

Current Medications:

Over the counter medication (please list) _____

Prescription medication (please list) _____

Others/supplements (please list) _____

Please list any medication you are allergic to _____

Please list any allergies and reactions: (include dietary allergies) _____

Previous surgeries (please list all) Date

1. _____ _____

2. _____ _____

3. _____ _____

PRIMARY CARE PHYSICIAN INFORMATION

Doctor's Name _____ Specialty _____

Address _____ City _____ Zip _____

Telephone _____ Last Date of Visit _____

In order to provide complete care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize Foundation Spine & Posture to contact your physician, request medical records, and/or co-manage your healthcare needs.

_____

Patient Name (Please Print) Date Patient Signature

_____

Minor's Name (Please Print) Date Guardian Signature

AUTHORIZATION & PRIVACY

AUTHORIZATION FOR CARE

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative traction and 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 for all services rendered.

Patient's Name (Please Print)	Date	Patient Signature
Minor's Name (Please Print)	Date	Guardian Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES FOUNDATION SPINE & POSTURE TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Foundation Spine & Posture to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email 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 Foundation Spine & Posture 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 Foundation Spine & Posture 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 form
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 operation.

Patient Name	Patient Signature	Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND FINANCIAL AGREEMENT:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern affiliated with Foundation Spine & Posture.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

Financial Agreement: I agree that in return for the services provided to me by Foundation Spine & Posture I will pay my account at the time service is rendered or will make financial arrangements satisfactory for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy insuring the patient or any other party liable to the patient is hereby assigned to Foundation Spine & Posture. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Foundation Spine & Posture accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services.
Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a scheduled appointment at Foundation Spine & Posture, I may be charged a cancellation fee which is at their discretion.

Assignment of Benefits: I agree that payments intended for Foundation Spine & Posture in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Foundation Spine & Posture to perform such. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Name (Please Print) **Date**

_____

Patient's Signature

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