APPLICATION FOR CARE AT CLARK FAMILY CHIROPRACTIC

*Whom may we thank for referring you to this office →*_________________________

Today's Date:___________

PATIENT DEMOGRAPHICS

Name:________________________________ DOB:____-____-____ Age:_____
- Male
- Female

Address:____________________________________ City:____________________ State:______ Zip:________

E-mail Address:____ Cell Phone:________________________

Marital Status:
- Single
- Married

Do you have insurance:
- Yes
- No

Social Security #:____________________________ Driver's License #:_________________________________

Employer:_________________________________ Occupation:_______________________________________

Spouse's Name:____________________________ Spouses's Employer:_________________________________

Number of children and Ages:_________________________________

Name & Number of Emergency Contact:___________________________________ Relationship:___________

HISTORY OF COMPLAINT

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

Secondary:______________________ 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 complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin?___________________ When is the problem at its worst?
- AM
- PM
- Mid-day
- Late PM

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

How did the injury happen?_____________________

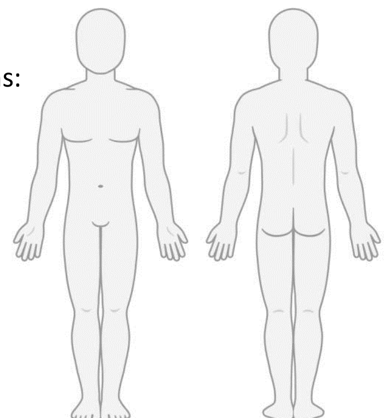
Condition(s) ever been treated by anyone in the past? ___No ___Yes If yes, when?:____________by whom?:_________

How long were you under care:____________________ what were the results?__________________________________

Name of previous Chiropractor:_____________________________________
- N/A

*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 relieves your symptoms?_____________________________________

What makes them feel worse?_____________________________________

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

Identify any other injury/injuries 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? • No • Yes

If yes, how many times?________ when was the last episode?__________ how did that injury happen?______________

Other forms of treatment tried? • No • Yes If yes, state what type of treatment:___________________________

Who provided it?________________ how long ago?______________What were the results?• Favorable • Unfavorable

Explain if unfavorable:____

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 ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer

___Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions

Please identify ALL PAST and CURRENT conditions you feel may be contributing to your present problem:

	How long ago	Type of care received	By whom
Injuries →			
Surgeries →			
Childhood Diseases →			
Adult Diseases →			

SOCIAL HISTORY

1. Smoking: • cigars • pipe • cigarettes → How Often? • Daily • Weekends • Occasionally • Never
2. Alcoholic Beverage: consumption occurs → • 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 pg 2

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ___No ___Yes
   If yes whom:___________________
   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 Clark Family 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 Clark Family Chiropractic for any and all services I receive at this office.

___________________________________ ____________________

Patient's Signature Date

___________________________________ ____________________

Doctor's Signature Date

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Activities of Daily Living/Symptoms/Medications

Patient Name:____________________________
File#_________
Date:________________

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 or 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	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfun.	___Heartburn
___Jaw Pain/TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Should Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain w/cough/sneeze	___Ringing in ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or knee problems	___Hearing loss	___Menstrual Problems	___Difficulty Breathing
___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS	___Lung Problems
___Back Curvature	___Swollen/Painful joints	___Irritable	___Bed Wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall bladder trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Eating Disorder	___Liver Trouble
___Numb/Tingling legs, feet, toes		___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:____
____
____

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CLARK FAMILY CHIROPRACTIC OFFICE POLICY

Welcome to Clark Family 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 to 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 treatment, 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 doctor at this office practice chiropractic care 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 of the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe first hand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reap 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 take 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 Clark Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CPB, Toggle, Gonstead, and Activator. 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 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 maintaining 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, you will be scheduled for a "Doctor's 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 wished 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 objects 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.

I hereby acknowledge receiving a copy of the practices "office policies", the first page of which I have read and retained. This 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 Name Date

________________________________ ____________________

Patient Signature Date

________________________________ ____________________

Witness Date

APPLICATION FOR CARE AT CLARK FAMILY CHIROPRACTIC

CLARK FAMILY 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 statements below, 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. Once you have read this notice, please sign the bottom. If you would like a copy for your records, one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean 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 local 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 many 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 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: For 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 and update you of changes in practice hours or upcoming events
11. Change of ownership: in the event this practice s 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 detailed privacy notice
3. To request mailings to an address difference 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 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 the cost

I understand my rights as well as the practice’s 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 any 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 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 Name Date

____ ________________

Patient Signature Date

____ ________________

Witness Date

I give permission to ________________________________ to view/have access to ______________________________________

____ ________________

Patient Signature Date

APPLICATION FOR CARE AT CLARK FAMILY CHIROPRACTIC

CLARK FAMILY CHIROPRACTIC TERMS OF ACCEPTANCE

When a patient seeks care and we agree to provide care, it is essential for the patient and Clark Family Chiropractic to be working toward the same objective. Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if during the course of your examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the 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 God-given, innate wisdom.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office and what is available today, thanks to progress in spinal health care.

> Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.
>
> Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible.

As a rule, informed and cooperative patients can achieve positive Chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic treatment. While recognizing the benefits of a health nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

> Family check-up: Spinal conditions are often silent and can go unnoticed by family and doctors for years. While we do not ask anyone to get care against their will, we do ask that all families receive a spinal check-up to discover whether significant spinal health issues exist.
>
> Corrective care: 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 goes beyond simple pain relief and into what it will take to actually correct or optimize the normal position of your spine and central nervous system.
>
> Wellness care: Spinal neglect is so common. It has become an epidemic in our society – despite the fact that your spine and nervous system control all function and healing in your body. Getting back to maintenance is the ultimate goal if Chiropractic. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.

I, ________________________________, have read and fully understand the above statements.

I understand the statements above regarding examinations and treatment in this office. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

____ ______________________

Patient Signature Date

Consent to evaluate and 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 of Parent or Guardian Date

Pregnancy Release:

This is to certify that to the best of my knowledge; I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: __________________

☐ N/A ☐ Currently Pregnant

____ ______________________

Patient Signature Date