ENLIGHTEN CHIROPRACTIC

PRACTICE MEMBER APPLICATION

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Phone: Cell_____ Home_____

Social Security #: _____Email:_____

Occupation_____ Employer's Name_____

Status: Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children_____ Names, Ages, & Gender_____

EMERGENCY CONTACT: _____ Relationship: _____

Who may we thank for referring you?_____

List The Health Concerns That Brought You Into This Office

Health Concern(s): List according to severity.↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	_____
Second:_____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? □ Yes □ No

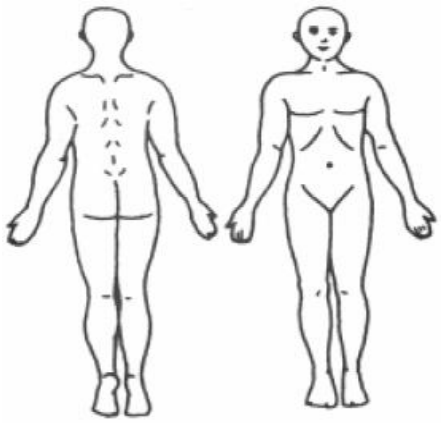
If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

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 your symptoms feel worse?

_____

When is the problem(s) at its worst? → AM PM Mid-Day Late PM

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

Name:_____ Date of Birth:_____

List all **over the counter & prescription medications** you are on, & the reason for each:

_____

Have you ever been in an auto accident? List all:_____

Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

Other trauma:_____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headache	___ Migraines	___ 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
___ Shoulder 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 Problem	___ 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 Disabilty	___ 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)
___ Nervousness	__ Sciatica	___Ear Infections	___Thyroid Issues	____Infertility
___Allergies	___ Loss of Energy	____ Anxiety	____Fibromyalgia	___Chest pain
Pregnant Due Date?_____		**___ Stroke**	**___ Cancer**	**____Heart attack**
___Spinal Surgery	**___Spinal Bone Fracture**	**___ Diabetes**	**___Arthritis**	**___Seizures**

OTHER: _____

Patient/ Authorized person's Signature **DATE:**

Doctor's Signature **DATE Reviewed:**

Name:_____ Date of Birth:_____

ACTIVITIES OF LIFE

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

ACTIVITY:	EFFECT:			
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
Example: Climbing stairs	I can climb 2 flights before it hurts	I used to climb 10+ fights without pain
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/ Authorized Person's Signature: _____ ***Date:*** _____

Doctor's Signature:_____ ***Date Reviewed:***_____

Name:_____ Date of Birth:_____

SOCIAL HISTORY

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours? □ Yes □ No

FAMILY HEALTH HISTORY

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

Name:_____ Date of Birth:_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

☐ Witness Initials

((If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child))

Name of practice member who is a minor/child: _____

I authorize Dr. Katie Muller and any and all Enlighten Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Enlighten Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Name:_____ Date of Birth:_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor(s) at Enlighten Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

** **FEMALES ONLY:** To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Enlighten Chiropractic.

Print Name:

Signature: _____ Date: _____

☐ Witness Initials

Name:_____ Date of Birth:_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked.

If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pai- Worst possible pain

Headache Low back

0 1 2 3 4 5 6 7 8 9 10

1.How would you rate your pain <u>RIGHT NOW</u>?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or <u>AVERAGE</u> pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

OTHER COMMENTS: _____

_____

SIGNATURE: _____ DATE: _____

Name:_____ Date of Birth:_____

Authorization for Use or Disclosure of Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Enlighten Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images and/or testimonial will be used for: *In-office material*, *Merchandise*, *Social Media and/or Advertising*

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

Treatment Conditions:

I understand that the practice cannot and will not condition treatment based on whether or not I sign this authorization.

Signature: _____ Date:_____

Parent/Guardian Signature (If MINOR) _____