SC CA

PCH CHIROPRACTIC

ORGANIC HEALTHCARE

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based, chiropractic spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal chiropractic program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

PATIENT NAME

_____

DATE COMPLETED

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Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

For Pediatric Patient (AGES 17 AND YOUNGER)

Name of Mother/Guardian: _____ Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: _____ Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: _____ /_____ /_____

Describe: _____

_____

Please use the General Symptoms Chart on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ Work ❑ School ❑ Sleep ❑ Hobbies ❑ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

Have you been treated for this? ❑ Yes ❑ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

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Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No Who?_____

Reason for visit(s):_____

Did your previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis?_____

Did he or she recommend a specific course of care? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what?_____ How long were you cared for?_____ Last visit: _____ / _____ / _____

How did you respond?_____

Are you aware of any poor posture habits? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain:_____

_____

_____

Health & Lifestyle

Do you exercise? ❑ Yes ❑ No How often? _____ day(s) per week; Other: _____

What activities? ❑ Walking ❑ Running/Jogging ❑ Weight Training ❑ Cycling ❑ Yoga ❑ Pilates ❑ Swimming ❑ Other: _____

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

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

Do you drink coffee? ❑ Yes ❑ No How much? / How often?_____

Do you take any supplements (i.e. vitamins, minerals, herbs)?_____

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident (***if you check this item, please ask the front desk person for the corresponding form***)
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s):_____

_____

BIRTH EXPERIENCE:

How long was labor?_____

Describe any complications: _____

_____

Type of delivery: ❑ Vaginal ❑ C-Section ❑ Vacuum Extraction ❑ Forceps Assistance

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VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received: _____

2. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received: _____

3. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received: _____

4. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received: _____

5. _____ Age: _____ ❑ Mos. ❑ Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site
____ Body rash or hives
____ High fever (over 103 degrees)
____ High-pitched screaming
____ Extreme sleepiness or unresponsiveness
____ Body twitching or paralysis
____ Breathing problems (asthma, etc.)
____ Excessive bleeding or anemia
____ Head banging
____ Excessive diarrhea or chronic constipation
____ Loss of memory/foggy state
____ Muscle weakness
____ Chronic ear or respiratory Infections
____ Vision or hearing disturbances
____ Joint pain
____ Crossing of eyes
____ Seizures
____ Other (please explain)

Please explain: _____

_____

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Headaches
____ Sinusitis
____ Pain in shoulders/arms/hands
____ Dizziness
____ Allergies/Hay fever
____ Numbness/tingling in arms/hands
____ Visual disturbances
____ Recurrent colds/Flu
____ Hearing disturbances
____ Coldness in hands
____ Low Energy/Fatigue
____ Weakness in grip
____ Thyroid conditions
____ TMJ/Pain/Clicking

Please explain: _____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Recurrent Lung Infections/Bronchitis
____ Heart Murmurs
____ Asthma/Wheezing
____ Tachycardia
____ Shortness Of Breath
____ Heart Attacks/Angina
____ Pain On Deep Inspiration/Expiration

Please explain: _____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

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THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Nausea
____ Diabetes
____ Pain in Ribs/Chest
____ Ulcers/Gastritis
____ Hypoglycemia/Hyperglycemia
____ Indigestion/Heartburn
____ Reflux
____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

_____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Weakness/injuries in hips/knees/ankles
____ Low back pain
____ Numbness/tingling in legs/feet
____ Recurrent bladder infections
____ Coldness in legs/feet
____ Frequent/difficulty urinating
____ Muscle cramps in legs/feet
____ Sexual dysfunction
____ Constipation/Diarrhea
____ Menstrual irregularities/cramping (females)

Please explain: _____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

_____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

_____

_____

_____

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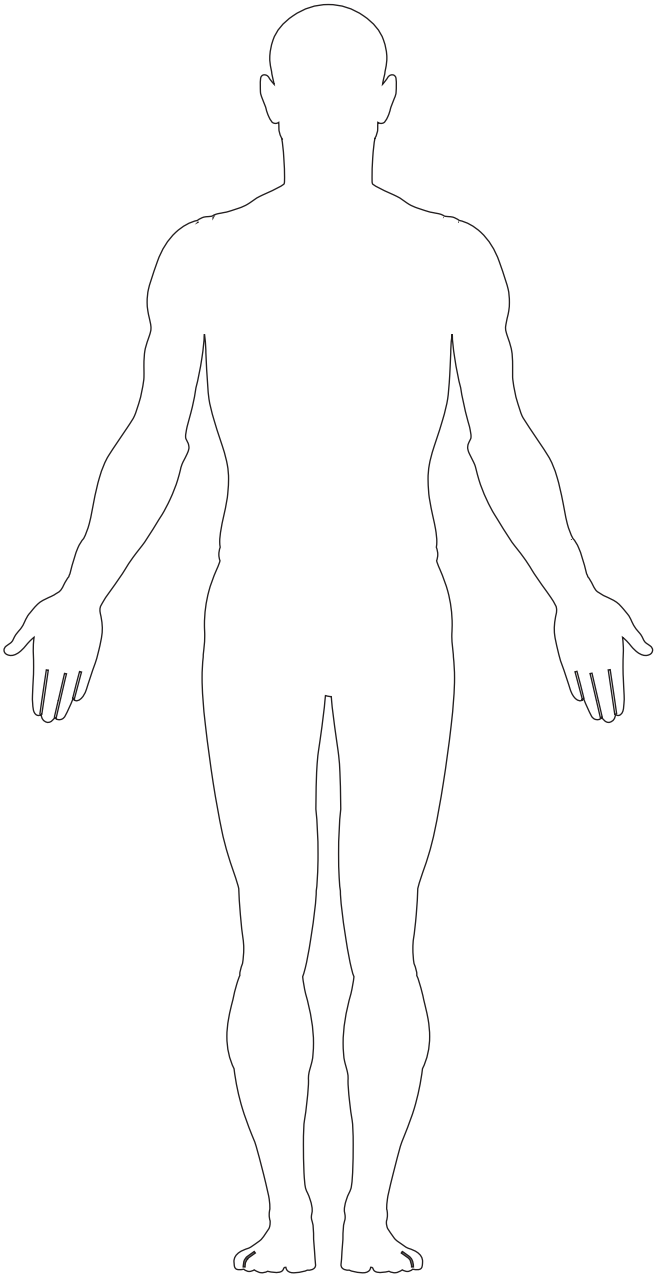
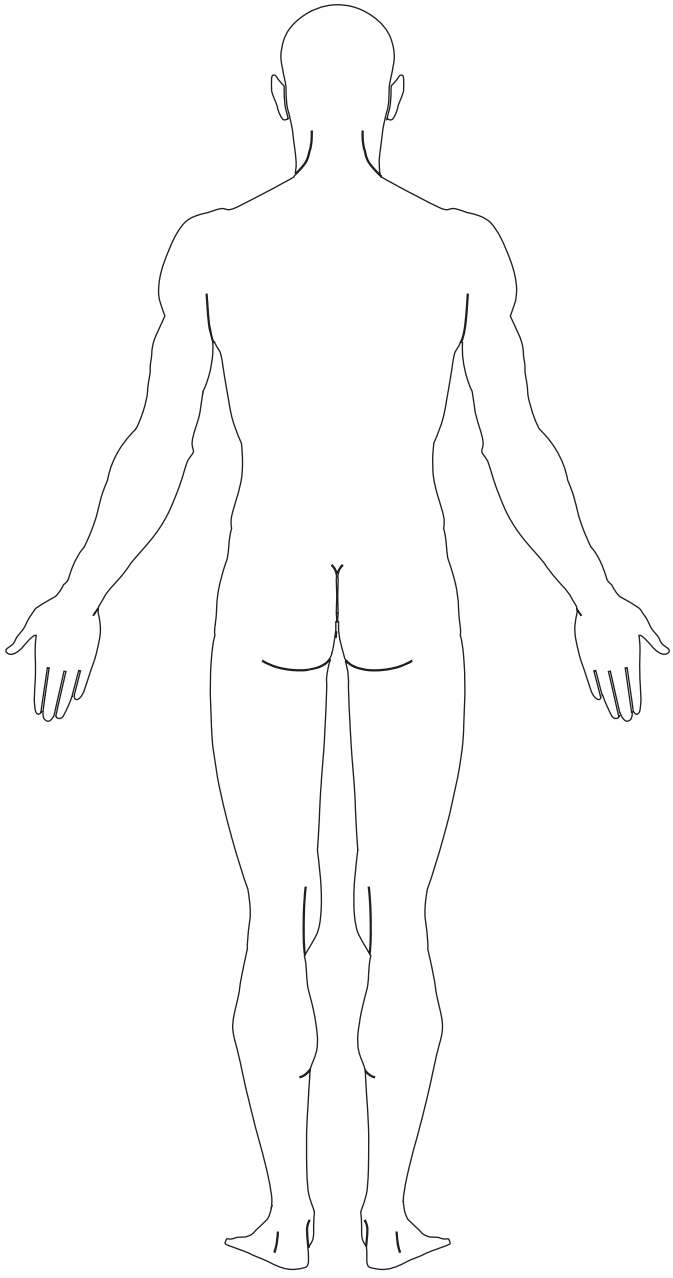
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked “O” for Other on any part, please explain below:

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Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

PREGNANCY RELEASE

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

Date of last menstrual cycle: _____/ _____ /_____

Patient's Signature _____ Date _____/ _____ / _____

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical 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 and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare 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 doctors and/or staff'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.

Patient's Signature _____ Date _____/ _____ / _____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for care, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____/ _____ / _____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

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Insurance

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for care you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot provide you with a receipt/superbill unless you provide us with the necessary billing information, and agree to permit us to release the necessary medical information required for you to secure payment. We will assist you in ensuring that your insurance carrier properly processes your services for payment.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Patient's Signature _____ Date _____ /_____ /_____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____ /_____ /_____

Relationship to Insured _____ Date of Birth _____ /_____ /_____

Employer _____

Primary Insurance Company _____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - _____ - _____

Secondary Insurance Company _____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - _____ - _____

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