Application for Care

Welcome, _____!
First Last MI

Today, ___/___/_____, I was referred to Pure Family Chiropractic by: _____.

I understand that referrals have built this practice and I ☐DO or ☐DO NOT (please check one) give permission to use my name in giving thanks for my future referrals.

I prefer to be called _____. I am ☐male ☐female (please check one) and was born on: ___/___/_____ making me ___ years young. I am ___'___" tall and my weight is _____lbs. The last 4 digits of my SSN# are _____, but I understand that I will never be treated as a number at Pure Family Chiropractic.

My mailing address is: _____
Street Address City State Zip Code

My email address is: _____

I can be reached at: Cell: _____Home: _____

I give permission to send me emails & text message reminders: ☐YES or ☐NO. My cell-phone carrier (e.g. Verizon, AT&T, etc.) is _____. If yes, how long prior to your visit would you like a reminder? 1 Day / 4 Hours / 2 Hours / 1 Hour

My employer is _____. I have worked there _____ years. I work as a(n) _____.

I am currently: ☐ Married ☐ Single ☐ Minor

The following is a list of my family members: _____
Spouse's Name Age

_____
Child's Name Age

_____
Child's Name Age

_____
Child's Name Age

How often are you or have you been adjusted by a chiropractor? _____

How do you rate your posture? (Poor) 0 1 2 3 4 5 6 7 8 9 10 (Excellent)

Subluxations (spinal misalignments) cause degeneration (arthritis) over time. The major cause of subluxations is stress. How do you rate your stress level over the last 3 months?
(Low) 0 1 2 3 4 5 6 7 8 9 10 (High)

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Subluxations often result from daily traumas, auto accidents, work accidents, medical conditions, etc. If you have had an injury, please tell us when it was:
Home _____ Auto _____ Slip or Fall _____

_____

Please circle YES or NO to any past or current health concerns that you have experienced:

Y N Heart Attack	Y N Heart Surg. / Pacemaker	Y N Venereal Disease	Y N Tuberculosis
Y N Stroke	Y N Alcohol / Drug Abuse	Y N Frequent Neck Pain	Y N Arthritis
Y N Artificial Valves	Y N Cancer	Y N Rheumatic Fever	Y N Congenital Heart Defect
Y N High Blood Pressure	Y N Chemotherapy	Y N Sinus Problems	Y N Psychiatric Problems
Y N Low Blood Pressure	Y N Fainting/Seizures/Epilepsy	Y N Lower Back Problems	Y N Ulcers / Colitis
Y N Difficulty Breathing	Y N Heart Murmur	Y N Hepatitis	Y N Emphysema / Asthma
Y N Artificial Bones/Joints	Y N Mitral Valve Prolapse	Y N HIV/AIDS/ARC	Y N Headaches
Y N Anemia	Y N Diabetes	Y N Kidney Disease	Y N Glaucoma

Y N Other: _____

Please list any surgeries or procedures you have had performed, including dates:

_____

Prescription medication is sometimes necessary, but it can also affect your care and your ability to heal. To help us better serve you, please list any medications you are currently taking:

_____

Women Only: Are you pregnant or is there any chance you may be pregnant or trying to get pregnant? YES or NO Are you currently taking birth control? YES or NO
If yes, what type? _____

Please list any nutritional supplements you are currently taking: _____

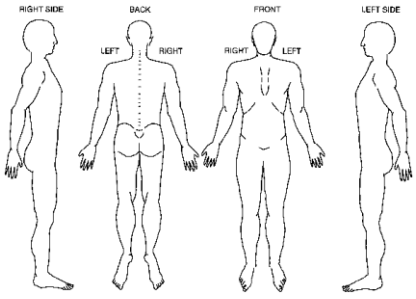
How do you rate your eating habits? (Poor) 0 1 2 3 4 5 6 7 8 9 10 (Excellent)

Are you interested in learning more about healthy eating and/or supplementation? YES or NO

How often do you exercise? _____ Hrs/Wk Do you or have you ever smoked tobacco products? YES or NO How often? _____/day How long? _____years

Please rate your pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)

Using the body charts, please mark any and all pain you are currently experiencing:



Have you been treated by a medical physician for this condition? YES or NO
Physician's Name _____
Have you been cared for by a chiropractor for this condition? YES or NO
Physician's Name _____

I have read the HIPAA guidelines and understand that my health information will not be shared with anyone without my consent:
Signature: _____

INSURANCE SUBMISSION AND ASSIGNMENT

As a courtesy to you, our office will submit insurance claims on your behalf. We will call and verify your benefits, but please be advised of the following:

Quotation of benefits is not a guarantee of payment by an insurance company. You will be subject to the terms and limitations of your policy and any exclusion that may apply at the time.

We will bill your insurance company, but it is your responsibility to pay all deductible amounts, co-pays, co-insurance and any other amounts left uncovered by insurance. Co-pays and co-insurance will be expected to be paid at the time services are rendered.

In the event that an insurance company would reject or deny your claim, it will be your responsibility to pay any charges and pursue re-imbursement from the insurance company.

Please read above carefully.

I hereby agree to abide by the above provisions:

_____ _____

Signature Date

Informed Consent for Chiropractic Care

Nature of Chiropractic Care: The doctor will use his/her hands or a mechanical device in order to adjust your joints, thus allowing the nerves to work without impairment. You may feel a "click" or "pop," such as the noise when a knuckle is "cracked;" this noise is from gas bubbles stored within the joint. You may also feel the movement of the joint. Various ancillary procedures such as hot or cold pack, or electric muscle stimulation may also be used.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation complex; however, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Possible Risks and Occurrences: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include muscular strain, ligamentous sprain, fractures of bone, rib injury, soft tissue injury, dislocations of joints, or injury to intervertebral disc, nerve or spinal cord. The risk of these complications due to chiropractic care have been described as "rare," about as often as complications of taking a single tablet of aspirin. A minority of patients may notice stiffness or soreness after the first few days of care. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. This risk has been estimated between one in one million and one in ten million. The risk is even further reduced by screening procedures. The ancillary procedures could produce skin irritation, burns, or other minor complications. The probably of this happening is also considered "rare."

Other Treatment Options through Medical Means:

Over-the-Counter Analgesics: The risks of these medications include irritation to the stomach, liver, and kidneys in a significant number of cases.
Medical Care: Typically anti-inflammatory drugs, tranquillizers, and analgesics. Risks of these drugs include a multitude of undesirable effects and patient dependence in a significant number of cases.
Hospitalization: In conjunction with medical care adds the risk of exposure to virulent communicable disease in a significant number of cases.
Surgery: In conjunction with medical care adds the risk of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.
Remaining Untreated: Delay in care allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of care will complicate the condition and make future rehabilitation more difficult or impossible.

I have read the above explanation of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing care. I have freely decided to undergo the recommended care and hereby give my full consent to care.

Printed Name	Signature	Date

Printed Name (Minor)	Signature of Legal Guardian	Date

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