empowered chiropractic

PATIENT APPLICATION FORM

We specialize in assisting 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 let you know 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 M F Marital Status S M W D

Email_____ Social Security_____

Address_____ City_____ Zip_____

Cell Phone_____ Home Phone_____

Occupation_____ Employer Name_____

Emergency Contact_____ Phone_____

Who can we thank for referring you to Empowered Chiropractic?_____

PURPOSE OF THIS VISIT

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

Are these conditions getting worse? ☐ Yes ☐ No ☐ 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

Is there anything that relieves your symptoms?

☐ Ice ☐ Heat ☐ Massage ☐ Resting ☐ Exercise ☐ Sitting ☐ Standing

☐ Bracing/Taping ☐ Stretching ☐ 'Popping' Joints ☐ Laying ☐ Other_____

PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? ☐ Yes ☐ No Where?_____

Do you experience numbness /tingling anywhere? ☐ Yes ☐ No Where?_____

Who have you seen this for?_____ 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 and 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 affects 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?_____

What activities do you do?_____

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

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

Do you drink coffee? ☐ Yes ☐ No How many cups/day?_____

List any supplements you are taking:_____

Do you eat any of the following?

☐ Soy ☐ Corn ☐ Gluten/wheat ☐ Eggs ☐ Red meat ☐ Pork

☐ Milk ☐ Cheese ☐ Yogurt ☐ Boxed or Frozen Foods ☐ Artificial sweeteners

Do you need to improve in any of these areas?

☐ Energy level ☐ Concentration ☐ Relaxation ☐ Memory ☐ Sleep ☐ Outlook on life

☐ Emotional balance

HEALTH LIFESTYLE (continued)

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 from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. The misalignments are called subluxations. 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 have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called forward head syndrome. Please check any health condition you may be experiencing, now or in the past:

Cervical Spine (Neck)

Do you experience any of the following? (Please circle all that apply)

Neck Pain	Thyroid Conditions	TMJ/Pain/Clicking	General Fatigue
Headaches	Dizziness	Hearing disturbances	Allergies
Insomnia	Low Metabolism	Visual disturbances	Depression/anxiety
Difficulty focusing/ADHD	Difficulty losing weight	Recurrent cold/flu	Skin issues
Coldness/sweaty hands	Brain fog/difficulty focusing	Pain into shoulders/arms/hands	Sinusitis
Numbness/tingling in arms/hands	Weakness in grip		

Thoracic Spine (Upper back)

Do you experience any of the following? (Please circle all that apply)

Heart palpitation	Heart murmurs	Asthma/wheezing	Tachycardia
Shortness of breath	Heart attacks/angina	Lung infections/bronchitis	Pain on deep inhalation/exhalation

Thoracic Spine (Mid back)

Do you experience any of the following? (Please circle all that apply)

Mid back pain	Nausea	Indigestion/heartburn	Hypoglycemia
Pain into ribs/chest Ulcers/gastritis	Acid reflex		
Tired/irritable after eating or when you haven't eaten			

Lumbar Spine (Low back)

Do you experience any of the following? (Please circle all that apply)

Pain into hips/legs/feet	Weakness/injuries in hips/knees/ankles	Numbness/tingling in legs/feet
Recurrent bladder infection	Coldness in legs/feet	Frequent/difficulty urinating
Muscle cramps in legs/feet	Menstrual irregularities/cramping	Constipation/diarrhea/bloating
Sexual dysfunction Low back pain		

Shoulder Injury? ☐ Yes ☐ No Surgery? _____ Date:_____

Knee Injury? ☐ Yes ☐ No Surgery?_____ Date:_____

MEDICAL HISTORY

Do you or any one in your family been diagnosed with any of the following? Circle all that apply:

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

Current Medications:

Over-the-counter medications:_____

Prescription medications:_____

Others/supplements:_____

Allergies to medications?_____

Any allergies and reactions (include dietary allergies):_____

Previous surgeries (all types):

1._____ Date:_____

2._____ Date:_____

PRIMARY CARE PHYSICIAN INFORMATION

Doctor's name:_____ Specialty:_____

Address:_____ City:_____ Zip:_____

Telephone:_____ Last date of visit:_____

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

_____

Patient's Name (please print) Date Patient's Signature

_____

Minor's Name (please print) Date Guardian's Signature

AUTHORIZATION & PRIVACY

AUTHORIZATION CARE

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative 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's Signature

_____

Minor's Name (please print) Date Guardian's Signature

HEATHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES EMPOWERED CHIROPRACTIC TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Empowered Chiropractic to use my name, address, phone numbers, and clinical records to contact me with birthday cards, holiday 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 Empowered Chiropractic 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 the doctor in private, the doctor will provide a private room for these conversations.

By signing the following you are giving Empowered Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGMENT OF RECEIPT & 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 contract
- 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 the office to carry out treatment, payment, or health care operation

_____

Patient's Name (please print) Date Patient's Signature

_____

Doctor's Name (please print) Date Doctor's Signature

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 names below, for whom I am legally responsible by the doctor affiliated with Empowered Chiropractic.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks of 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 Empowered Chiropractic I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Empowered Chiropractic 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 Empowered Chiropractic. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of this bill

Empowered Chiropractic accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductibles, 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 Empowered Chiropractic, I may be charged a cancellation fee which is a the discretion of Empowered Chiropractic.

Assignment of Benefits:

I agree that payments intended for Empowered Chiropractic 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 will be repaid to Empowered Chiropractic.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor affiliated with Empowered Chiropractic to perform such. 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's Name (please print) Date Patient's Signature

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