PATIENT APPLICATION FORM

We specialize in helping 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. Please fill out the following information thoroughly so the doctor can determine 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 INFORMATION

Full Name_______________ Today's Date _______________

Date of Birth_______________ Age_______ Marital Status (Optional) S M W D

What is your current gender identity? Male Female Transgender M Transgender F Gender Queer Decline to answer

Email _______________ Social Security (Optional) _______________

Address_______________ City_______________ Zip_______________

Home Phone_______________ Cell Phone _______________

Preferred Method of Contact _______________ Is it okay to leave voice messages regarding your appointments? Yes No

Is it okay to email you with reminders of upcoming appointments? Yes No

Occupation_______________ Employer_______________

Emergency Contact Person/Relationship_______________ Phone _______________

Who Should We Thank for Referring You to Foundation Spine & Posture? _______________

PURPOSE OF THIS VISIT

	Health Issue	Date Condition Started/How	How Long Does it Last During Day?	Severity (0-10)
1				
2				
3				
4				
5				
6				

Are these conditions getting worse? ❑ Yes ❑ No Frequency: ❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent ❑ Activity Related

How would you describe your pain / discomfort (check all that

❑ Dull ❑ Achy ❑ Throbbing ❑ Stiff ❑ Sharp ❑ Stabbing ❑ Shooting

❑ Tight ❑ Burning ❑ Bruised ❑ 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 ❑ Lying Down ❑ Movement

Other: ________

PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? ❑ Yes ❑ No

If yes, where? ________________ Severity? (0-10/10) ________ How long does it last? ________

Do you experience numbness and tingling anywhere? ❑ Yes ❑ No If yes, where? ________________

Who have you seen for this? ________________ 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 poor posture habits in your spouse or children? ❑ Yes ❑ No

Please Explain: ________________

HEALTH LIFESTYLE

Do you exercise? ❑ Yes ❑ No How often? 1x 2x 3x 4x 5x per week Other: ________

What activities? ❑ Running/Walking ❑ Weight Training ❑ Cycling ❑ Yoga/Pilates ❑ Other: ________

Do you smoke? ❑ Yes ❑ No How much? ________________

Do you drink alcohol? ❑ Yes ❑ No How much/week? ________________

Do you drink caffeine? Yes ❑ Yes ❑ No How many/day? ________________

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

Note: 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/shifted from their normal position, they will cause stress to the spinal cord and/or nerves that pass between the vertebrae. These 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 which results in a weakened and distorted posture. Postural distortions can have many serious and adverse effects on your overall health. On the next page, please check any health conditions you may be experiencing, now or in the past.

HEALTH LIFESTYLE (continued)

CERVICAL SPINE (NECK)
Postural distortions from subluxations in your neck can weaken the nerves into your arms, hands and head affecting these parts of your body. Do YOU experience (either now or in the past):

- ❑ Neck Pain
- ❑ Thyroid Disorders
- ❑ TMJ/Pain/Clicking-Jaw
- ❑ General Fatigue
- ❑ Headaches/Migraines
- ❑ Sinusitis
- ❑ Dizziness
- ❑ Insomnia /sleep disorders
- ❑ Allergies
- ❑ Ringing in ears
- ❑ Blurry Vision/ Double Vision
- ❑ Low Metabolism
- ❑ Recurrent colds/flu
- ❑ Weakness in grip
- ❑ Coldness in hands
- ❑ Difficulty Losing Weight
- ❑ Immune system weakness
- ❑ Forgetfulness/memory loss
- ❑ ADHD/difficulty focusing
- ❑ Anxiety / Depression
- ❑ Whiplash ______________
- ❑ Balance/Coordination Issues
- ❑ Brain Fog
- ❑ Skin Issues ie Acne, Eczema
- ❑ Pain into your shoulders /arms/hands
- ❑ Numbness/tingling in head/arms/hands (please circle)

THORACIC SPINE (UPPER BACK)
Postural distortions from subluxations in the upper back can weaken the nerves to the heart and lungs and affect these parts of your body. Do YOU experience (either now or in the past):

- ❑ Heart palpitation
- ❑ Heart murmurs
- ❑ Asthma/ wheezing
- ❑ Tachycardia
- ❑ Shortness of breath
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Pain on deep inhalation / exhalation
- ❑ Persistent cough

THORACIC SPINE (MID BACK)
Postural distortions from subluxations in the mid back can weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do YOU experience (either now or in the past):

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

LUMBAR SPINE (LOW BACK)
Postural distortions from subluxations in the low back can weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do YOU experience (either now or in the past):

- ❑ Low back pain
- ❑ Pain into your hips/legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Pain into groin/inner leg
- ❑ Gassiness/Bloating
- ❑ Numbness/tingling in your legs/feet
- ❑ Recurrent bladder infection
- ❑ Coldness in your legs/feet
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in your legs/feet
- ❑ Menstrual irregularities/cramping (females)
- ❑ Constipation/diarrhea
- ❑ Sexual dysfunction/infertility

Please list any health concerns not mentioned: ____

MEDICAL HISTORY

Have you or any family members had or been diagnosed with the following? **Please check the box and mark "S" for self or "F" for family**.

❑ Diabetes	❑ Cancer- specify type:___________ ❑ Chemo / Radiation / Surgery (circle)	❑ Thyroid Disorder	❑ Multiple Sclerosis
❑ Psychiatric Disorder	❑ Anxiety/Depression	❑ Neurological Disorder (ie. Parkinsons)	❑ Seizures
❑ Blood Disorders (ie. Anemia, Clots, Hemophilia)	❑ Heart Attack	❑ Pulmonary Embolism	❑ Stroke or TIA
❑ Peripheral Vascular Disease	❑ Heart Murmurs	❑ High Blood Pressure	❑ Low Blood Pressure
❑ Liver Disease	❑ Gallbladder Disorders	❑ Migraines	❑ Disc Herniation
❑ Cauda Equina Syndrome	❑ Auto Immunity (ie: Lupus, Rheumatoid Arthritis)	❑ Fibromyalgia	❑ Arthritis
❑ Breathing/Sleep Problems (ie. Sleep Apnea, Snoring)	❑ Emphysema	❑ COPD	❑ Asthma
❑ Kidney Disorders	❑ Gout	❑ Digestive or Eating Disorder	❑ Concussion
❑ Scoliosis	❑ Osteoporosis/Osteopenia	❑ Joint Replacement	❑ Head/Neck Injury

Current Medications:

Over the counter medication (please list) ________________________________

Prescription medication (please list) ________________________________

Supplements/Herbs/Tinctures (please list) ________________________________

Previous surgeries (please list all) Date

1. ________________________________ ____________

2. ________________________________ ____________

3. ________________________________ ____________

PRIMARY CARE PHYSICIAN INFORMATION

Doctor's Name ____________________ Specialty____________________

Address____________________City____________________Zip __________

Telephone____________________Last Date of Visit (if known) ____________________

In order to provide complete care, we may communicate with your primary care physician **at your request** regarding past, present, and future health concerns. By signing below, you authorize Foundation Spine & Posture to contact your physician, request medical records, and/or co-manage your healthcare needs.

____

Patient Name (Please Print) Date Patient Signature

____

Guardian's Name of Minor (Please Print) Date Guardian Signature

AUTHORIZATION & PRIVACY

AUTHORIZATION FOR CARE

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative traction and 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 agree that in return for the services provided to me by Foundation Spine & Posture I will pay my account at the time service is rendered or will make financial arrangements satisfactory for payment. I understand and agree that if my account is delinquent, I may be charged a service fee. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered whenever applicable.

Patient's Name (Please Print)	Date	Patient Signature
Minor's Name (Please Print)	Date	Guardian Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES FOUNDATION SPINE & POSTURE TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Foundation Spine & Posture to use my name, address, phone numbers and clinical records to contact me via email regarding appointments or information about treatment or other health related information. I give permission to Foundation Spine & Posture 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 a doctor or physical therapist in private, the doctor will provide a private room for these conversations.

By signing the following you are giving Foundation Spine & Posture permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I, ______________________ understand that a notice of information practices is available to me for review on Foundation Spine & Posture's website and that provides me with a complete description of information uses and disclosures. I also understand a printed copy is available to me for my records if I wish to review it. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent form.
The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operation.

Patient Name	Patient Signature	Date
Guardian Signature of Minor	Date of Guardian's Signature	

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spine & posture

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT:

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 named below, for whom I am legally responsible) by the doctor affiliated with Foundation Spine & Posture. In this office I understand trained staff personnel may assist the doctor with portions of my consultation, examination, x-ray taking, physical therapy application, traction, exercise instruction, etc.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment which may arise during chiropractic treatments, 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.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

______________________________ __________________________________ ______________
Patient Name (Please Print) **Patient Signature** **Date**

____ ______________________________
Parent/Guardian Signature (if applicable) **Date of Guardian's Signature (if applicable)**