APPLICATION FOR CHIROPRACTIC CARE – WELCOME TO OUR OFFICE

NAME_____DATE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME_____CELL_____WORK_____

EMAIL_____

AGE_____ BIRTHDATE_____ MARITAL STATUS: M S W D # OF CHILDREN_____

OCCUPATION_____ EMPLOYER_____

SPOUSE _____OCCUPATION_____EMPLOYER_____

REFERRED BY_____

INSURANCE INFORMATION: AUTO ACCIDENT_____ WORKMEN'S COMP_____ GROUP INS._____

MEDICAL ASSIST._____ MEDICARE_____ PERSONAL PAYMENT_____ INS. CO. NAME_____

PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

ACCIDENT INFORMATION: DESCRIBE_____

LOCATION_____DATE_____TIME_____AM PM

WAS POLICE REPORT MADE_____WAS EMPLOYER NOTIFIED_____

LAST DAY WORKED_____ARE YOU ON DISABILITY_____

REQUIRED INFORMATION: PREVIOUS CHIROPRACTIC CARE? YES___ NO___ DR.'S NAME_____

DATE OF LAST ADJUSTMENT_____RESULTS_____

PLEASE CHECK THE TYPE OF CARE YOU DESIRE SO THAT WE MAY BE GUIDED BY YOUR WISHES WHEN POSSIBLE

_____ I PREFER THE DOCTOR TO SELECT THE TYPE OF CARE HE FEELS IS BEST FOR ME

_____ MAXIMUM IMPROVEMENT AND PREVENTION IN THE FUTURE

_____ TEMPORARY RELIEF FOR THIS SPECIFIC PROBLEM

MAJOR COMPLAINT: _____

WHEN DID IT START_____HAVE YOU HAD THIS CONDITION BEFORE_____WHEN_____

IS THIS CONDITION GETTING WORSE? YES____ NO____ CONSTANT_____ COMES AND GOES_____

WHAT ACTIVITIES MAKE IT WORSE_____

DOES YOUR CONDITION INTERFERE WITH: WORK____ SLEEP____ DAILY ACTIVITY____

HAVE YOU TREATED FOR THIS CONDITION BEFORE? _____ DR.'S NAME_____

DIAGNOSIS_____

RESULTS: GOOD_____ FAIR_____ POOR_____ NONE_____

PLEASE CHECK THE APPROPRIATE BOS FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY. WE WANT ALL THE FACTS ABOUT YOUR HEALTH BEFORE WE ACCEPT YOUR CASE. THIS IS A CONFIDENTIAL HEALTH REPORT.

□ NECK PAIN
□ NECK STIFFNESS
□ NECK GRATING
□ NECK TENSION
□ WORSE AFTER SLEEP
□ DURING THE DAY
□ END OF DAY
□ MID BACK PAIN
□ MID BACK STIFFNESS
□ MID BACK GRATING
□ MID BACK TENSION
□ WORSE AFTER SLEEP
□ DURING THE DAY
□ END OF DAY
□ LOW BACK PAIN
□ LOW BACK STIFFNESS
□ LOW BACK GRATING
□ LOW BACK TENSION
□ WORSE AFTER SLEEP
□ DURING DAY
□ END OF DAY

PAIN IN:
□ SHOULDERS
□ ARMS
□ HANDS
□ HIPS
□ LEGS
□ KNEES
□ FEET

NUMBNESS IN:
□ SHOULDERS
□ ARMS
□ HANDS
□ HIPS
□ LEGS
□ KNEES
□ FEET

□ BURSITIS
□ HERNIA
□ PINCHED NERVES
□ HEADACHES
□ MIGRAINES
□ WORSE AFTER SLEEP
□ DURING THE DAY
□ END OF DAY
□ DIZZINESS
□ FAINTING
□ NERVOUSNESS
□ DEPRESSION
□ CONVULSIONS
□ BAD MOODS&BEHAVIOR
□TREMORS
□ INSOMNIA
□ SWEATS
□ CHILLS
□ BELCHING/GAS
□ COLON TROUBLE
□ CONSTIPATION
□ DIARRHEA
□ INDIGESTION
□ HEMORRHOIDS
□ NAUSEA
□ GALL BLADDER TROUBLE
□ LIVER TROUBLE
□ VOMITING
□ STOMACH ACHES
□ ASTHMA
□ ALLERGIES
□ SINUS
□ PAINFUL JOINTS
□ SWOLLEN JOINTS
□ CURVATURE OF THE SPINE

□ TONSILLITIS
□ HAY FEVER
□ SORE THROAT
□ EYE PAIN
□ FAILING VISION
□ EAR TROUBLES
□ RINGING IN THE EARS
□ NOSE BLEEDS
□ HIGH BLOOD PRESSRE
□ LOW BLOOD PRESSURE
□ CHEST PAINS
□ POOR CIRCULATION
□ CHRONIC COUGH
□ DIFFICULT BREATHING
□ SKIN ERUPTIONS
□ VARICOSE VEINS
□ ACNE
□ BOILS
□ ITCHING
□ BED WETTING
□ BLOOD IN URINE
□ FREQUENT URINATION
□ PAINFUL URINATION
□ KIDNEY TROUBLES
□ PROSTATE TROUBLE
□ MENSTRUAL CRAMPS
□ EXCESSIVE FLOW
□ IRREGULAR CYCLE
□ **ARE YOU PREGNANT**
□ MENOPAUSAL SYMPTOMS
□ PAINFUL TAILBONE
□ SCIATICA
□ SPINAL SURGERY
□ DISC SURGERY
□ LUMPS IN BREAST

CONDITIONS:
□ COLDS
□ FLU
□ ALCOHOLISM
□ ANEMIA
□ ARTERIOSCLEROSIS
□ ARTHRITIS
□ CANCER
□ CROUP
□ DIABETES
□ EPILEPSY
□ HEART DISEASE
□ MISCARRIAGE
□ MULT. SCLEROSIS
□ PNEUMONIA
□ POLIO
□ STROKE
□ T.B.
□ ULCERS
□ MENTAL DISORDER
□ OTHER_____

_____

_____

_____

_____

_____

LIST MEDICATIONS _____

LIST PAST FRACTURES _____

LIST PAST SURGERIES _____

LIST PREVIOUS ACCIDENTS _____

HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH PROBLEMS IN THE PAST YEAR?_____

Name _____ Date _____

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both are seeking and working toward the same goal.

Chiropractic has only one goal. It is, therefore, important that the patient understands that goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding or disappointment.

Patients usually want to get rid of whatever ailments or conditions that are bothering them. However worthy such a goal may be, it is not the goal of a chiropractor. Doctors of chiropractic do not engage in the medical practice of diagnosing and treating disease.

Chiropractic is based on the premise that living things have an inborn striving to maintain their own health. This striving is frequently referred to as the body's natural recuperative powers. A slightly misaligned vertebra, which interferes with the transmission of mental impulses over nerves, reduces the body's natural recuperative abilities and to maintain its own health.

The doctor of chiropractic's one goal is to periodically examine the patient's spine and should subluxation be detected, correct it by means of a straight chiropractic adjustment. This re-establishes a more normal nerve function. The single goal of the doctor of chiropractic is to correct subluxation for the purpose of removing this form of interference to the proper transmission of brain messages over nerve pathways so that every part of the body is better directed and controlled. The adjustment is not meant to be a panacea for all disease or a specific treatment for any particular disease.

The chiropractic examination and adjustment are not substitutes for other types of health care, just as other types of care do not take the place of chiropractic.

In some cases where disease and symptoms have been present, the removal of this form of interference renders the body sufficiently able to bring about a restoration of health very quickly. In others, the process is slower and in some cases it is only partial or not at all. Regardless of what the disease is called, the doctor of chiropractic does not diagnose, heal. The doctor of chiropractic corrects subluxations, this interference to the body's natural functioning.

I have read the above, understand it fully, and undertake chiropractic care on this basis.

Signature _____ Date _____

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("Consent Form")

For the purposes of this Consent Form, "Office" shall refer to: Meden Chiropractic.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):_____

Signature: _____ Date _____