



Patient Application Form

Welcome to our clinic. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural correction programs. Our approach is very different and more complete than other rehabilitative programs, which allows us to achieve superior correction as compared to other systems.

Please fill out the following information completely so the doctor can let you know if we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patients Name

Patients Signature

Date

PATIENT REGISTRATION

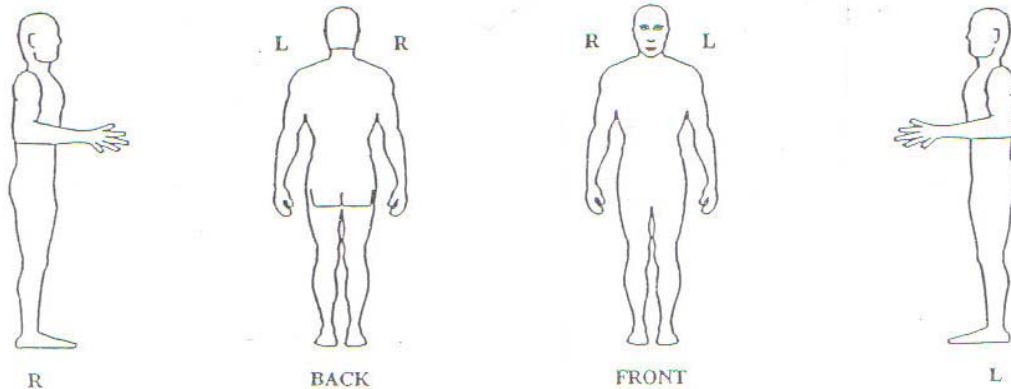
Title: Mr./Mrs./Ms./Dr./Rev./Rank _____ Date _____
Last Name _____ First Name _____ M.I. _____ Nickname _____
Address _____ City _____ State _____ Zip _____
Mobile Phone _____ Home Phone _____ Work Phone _____
E-Mail _____ SSN _____
Date of Birth _____ Age _____ Gender: M F Marital Status: S M W D
Employer Name _____ Occupation _____
Spouse Name _____ Phone _____
Spouses Employer _____ Occupation _____
Are you pregnant? Yes No If so how many weeks? _____
Children (names, ages) _____
Most of our patients are referred by a family member or friend, what made you decide to visit our office?
 Friend or Family Member Name _____
 Yellow Pages Website Presentation Sign Newspaper Other _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint _____
In this related is an auto accident or work injury? Yes No If yes, when _____
When did this condition begin? ___/___/___ Did it begin: Gradually Suddenly
What activities aggravate your symptoms? _____
Is there anything that has relieved your symptoms? Yes No Describe _____
Type of pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting
Does the pain radiate into your arms or legs? Yes No Is the condition getting worse? Yes No
How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity
Does your complaint interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain _____
Have you experienced this condition before? Yes No If yes, please explain _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____
Please list any other complaints:
1. _____
2. _____
3. _____
4. _____

AREA(S) OF COMPLAINT

Place "X's" on the area(s) where you have pain and draw lines to where it radiates:



HEALTH CONDITIONS

Posture distortions are the result of trauma or chronic poor posture. These distortions not only represent a change in the shape of the spine, but the stress it puts on the individual bones (vertebrae) causes them to be twisted from their normal position. This dysfunction, called a subluxation, puts stress on your spinal cord and the delicate nerves that pass between each of the vertebrae. The most common postural distortion is called "Head Forward Syndrome" which is a hunched forward posture that starts in the neck and has a domino effect on the rest of the spine weakening the entire spine and therefore body. Please mark any health condition you may be experiencing at present or in the past.

CERVICAL SPINE (NECK)

Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and head and can cause the following problems; do you have any of these?

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Coldness in hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Recurrent colds/flu |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> TMJ pain/clicking |

THORACIC SPINE (UPPER AND MID BACK)

Subluxations in your upper and mid back weaken the nerves that go to your lungs, heart, ribs/chest, and upper digestive tract; do you have any of these?

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Heart attacks/angina | <input type="checkbox"/> Recurrent lung infections/bronchitis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Pain on deep inspiration/expiration |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Indigestion/Heartburn |
| <input type="checkbox"/> Rib/chest pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ulcers/Gastritis |

LUMBAR SPINE (LOW BACK)

Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet; do you have any of these?

- | | |
|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness in your hips/knees/ankles |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Muscle cramps in your legs/feet |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Numbness/tingling in your legs/feet |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping |
| <input type="checkbox"/> Sexual dysfunction | |

Please list any health conditions not mentioned:

1. _____
2. _____
3. _____

Please list any medications you are currently taking and their purpose:

1. _____
2. _____
3. _____

Please list all past surgeries:

1. _____
2. _____
3. _____

Please list any previous accidents and injuries:

1. _____
2. _____
3. _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week Other _____

What activities? Running Weights Cycling Yoga Pilates Swimming Other _____

Do you smoke? Yes No How many packs per day? _____

Do you drink alcohol? Yes No What and how much? _____

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

Do you drink soda? Yes No How many per 12 oz. servings per day? _____

Do you drink water? Yes No How much per day? _____

Do you eat vegetables and fruits? Yes No How many servings per day? _____

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

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? Yes No Who? _____ When? _____

Reason for visits? _____

What treatments were given? _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No

Did you know your posture has a significant effect on your health? Yes No

Are you aware of any of your poor posture habits? Yes No Explain _____

Are you aware of any poor posture habits in your spouse or children? Yes No Explain _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a chiropractic and rehabilitation facility we have one main objective, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this objective, thus preventing any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: A specific application of force to facilitate the body's correction of vertebral subluxation.

We do not offer to treat symptoms, but rather to determine if a patient has subluxations. If present, we will recommend a course of treatment including adjustments and rehabilitation procedures in an effort to achieve maximum correction of this dysfunction.

PROCEDURES

- No Charge Consultation- This is a brief meeting between you and the doctor to determine if you may benefit from the care we provide. There is no financial obligation in connection with this service.
- Exam- After your consultation, if the doctor believes you will likely benefit from the care we provide, a thorough orthopedic, neurologic, and chiropractic examination will be recommended.
- X-Rays- Based upon the exam findings, the doctor may recommend selected x-rays be taken.
- Report of Findings- Included in the cost of the examination is a report of findings. This is where the doctor presents his findings regarding your health to you. The doctor will explain what he feels to be the best and fastest approach to improved health for you, if any.
- Treatments- Include spinal and extra spinal adjustments, intersegmental traction, interferential therapy, curve restoration traction, core muscle training, rehabilitation, posture correction exercises, decompression, custom orthotics, nutritional recommendations and supplements.

PAYMENT POLICY

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
 - Payment in full at the time of service entitles you to a 30% discount on all services.
- Health/Automobile Insurance
 - Your insurance coverage is a contract between you and your insurance company. We will gladly help you verify what your particular coverage is; however, we can not take responsibility for what your insurance does or does not cover. Ultimately, all services rendered to you are charged directly to you and you are responsible for payment.
 - We will file your insurance claim for you and do everything we can do to ensure you receive proper reimbursement.
 - If your policy has a deductible feature, it is due at the time of service.
 - We will do our very best to answer any questions you may have in regard to your insurance.
- There will be a \$25 charge on any returned checks (plus the original amount of the check)

By my signature below, I acknowledge that I have read and agree to the above TERMS OF ACCEPTANCE.

PATIENT SIGNATURE (or Parent/Guardian)

DATE

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, examination, traction, and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and/or by other office or clinic personnel.

POSSIBLE RISKS

I understand and am informed that, as in all health care, in the practice of chiropractic, there are some risks to treatment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness. The ancillary procedures could produce skin irritations, burns, or minor complications.

PROBABILITY OF RISKS OCCURRING

The risks of complications due to chiropractic treatment have been described as rare, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds 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 an extended convalescent period in a significant number of cases.

RISKS OF REMAINING UNTREATED

Can further reduce ranges of motion, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and delay of treatment allows formation of adhesions, scar tissue and other degenerative changes including arthritis. These changes make future rehabilitation more difficult.

CONSENT

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Informed Consent. I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to all my present and future chiropractic care.

PATIENT SIGNATURE (or Parent/Guardian)

DATE

Pregnancy Release (Female Only)

This is to certify that to the best of my knowledge I am not pregnant and Corrective Chiropractic has my permission to perform an X-Ray evaluation. I understand the risks of taking an X-Ray to an unborn child.

Date of last menstrual period _____ Initials _____

NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services provided to you. You may ask to see a copy of that record. We will not disclose your records to others unless you direct us to or unless the law authorizes or compels us to. You may see your record or get more information about it by contacting Dr. Jason Degenhardt, D.C.

- We may share your health information to run our office, collect payment, treat you, thank you for referring others, discuss your case with your family, include you in health care classes, help you collect from your insurance company, inform you about other services, provide assistance with your diagnosis or treatment from another provider or radiologist.
- We may use your health information for health and safety reasons, court hearings and filings, reporting to law officials and for reporting victims of abuse.
- We may call you by name in the reception area when the doctor is ready for to see you.
- A postcard may be mailed to you at the address provided by you.
- When telephoning your home we may leave a message with whomever answers or on your answering machine.
- We may include a photo of you on our referral wall.

You have the right to request a copy of your records, ask to limit the information we share, amend your health information, request a list of whom we share your records with, advise our management if you believe your privacy rights have been violated.

Our Notice of Privacy Practices, which you can request to view at any time, describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read, understand and agree to NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE (or Parent/Guardian)

DATE