

Date: _____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Address: _____ Home phone: () _____

City, State, Zip _____ Work phone: () _____

Email Address: _____ Cell phone: () _____

Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's name: _____ Spouse's Employer: _____

How were you referred to our office?: _____

Primary Care Doctor: _____ Phone: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before: ___ Yes ___ No Who? _____

Reason for visits: _____

How did you respond? _____

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

Did you know that posture determines your health? ___ Yes ___ No

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

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1x 2x 3x 4x 5x per week Other: _____
What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

So you smoke? Yes No How much? _____

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

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

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. These misalignments are called Subluxations (sub-lux-a-shuns). It has been 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 affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting at your neck and progressively moving down your spine weakening the entire body.) Please check any health condition you may be experiencing now or in the past.

CERVICAL SPINE: (NECK)

Postural distortions from subluxations, (causing Forward Head Syndrome) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain into shoulders/arms/hands | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Numbness/Tingling in arms/hands | <input type="checkbox"/> Recurrent Colds/Flu | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid conditions | <input type="checkbox"/> TMJ/Jaw Pain/Clicking |
- Explain: _____

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience: _____?

- | | |
|--|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Attack/Angina | <input type="checkbox"/> Pain on deep breath in/out |

THORACIC SPINE (MID-BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves in your ribs/chest and upper digestive tract and affect these parts of your body. Do you experience: _____?

- | | |
|--|--|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into your Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Indigestions/Heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating/ when you haven't eaten for awhile |

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the lower back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience: _____?

- | | | |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Numbness/tingling in your feet/legs | <input type="checkbox"/> Recurrent bladder infections | |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Menstrual irregularities/ Cramping (female) | |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Sexual dysfunction | |

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

Symptoms began on:

--	--	--

(Please fill in selections completely)

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

- (1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- (1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

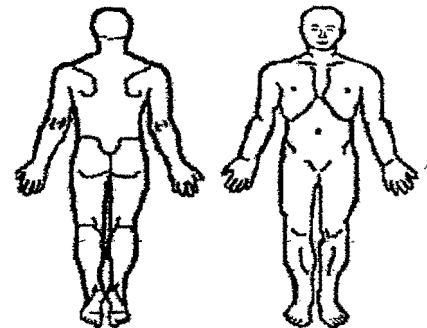
6. How is your condition changing, since care began at *this* facility?

- (0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

- (1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date: _____

INSURANCE INFORMATION

I hereby instruct _____ Insurance Company to pay by check made out to and mailed directly to Allen Family Wellness LLC, Annette S. Allen, D.C., P.O Box 13794, Arlington, TX 76094.

For professional or medical expense benefits allowable and otherwise payable to the Docotr under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND DENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photo-copy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor or Attorney involved in this claim.

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. Allen Family Wellness LLC will provide any necessary report or required information to aid in insurance reimbursement of services. Any monies received will be credited to my account. I certify that these office visits are not related to any personal injury or worker’s compensation case that is active of that has not been closed or finalized.

Patient/Legal Guardian Signature

Date

Insured Signature (if available/applicable)

Witness Signature

Acknowledgment of Receipt of Notice of Privacy Practices

I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides 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 consent
- ___ The right to object to the use of my health information for directory purposes, and
- ___ The right to request restrictions as to how my health information may be used or disclosed to carry out Treatment, payment or health care operations.

Texas Chiropractic Association Authorization

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Texas Chiropractic Association (TCS). This disclosure will be made if we need the TCS’s assistance to receive reimbursement for your services or, we need the TCA’s assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form, you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA’s legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and staff of Allen Family Wellness LLC may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternative, or other health relater information that may be of interest to your health. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature

Date

CONSENT TO CARE

Chiropractic is the use of a doctor's hands and/or a mechanical device in order to move your spine and nervous system. Various ancillary procedures, such as hot/cold packs, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy and /or physical therapy consisting of a series of weights/balances training may also be used.

Treatments provided by Chiropractors have been subject to much research over many years and have been deemed appropriate and effective for many common forms of spinal pain, pain in shoulder, arms and legs, headaches, and other similar symptoms. Treatment provided by Allen Family Wellness Center may also contribute to your overall well-being.

Clinicians who use manual spinal therapy techniques, such as joint adjustments/mobilization are required to inform patients that there are or may be risks associated with such treatment.

As with any health care procedure, there are possible risks. Complications could include muscular or ligament sprains, fractures of bone, dislocations of joints or injury to intervertebral discs, nerves or spinal cord. Cerebravascular injury or stroke could occur upon severe injury to arteries of the neck. The ancillary procedures could produce skin irritations, burns or minor complications.

The probability of risks occurring or complications sue to chiropractic treatment is very rare. The probability of adverse reaction due to ancillary procedures is also considered rare. The risk of injury or complication from manual treatment is substantially lower than the risk associated with many medications, other treatments and procedures frequently given as alternative treatments for the same forms of musculoskeletal pain and other associated syndromes.

The risks of remaining untreated or delaying treatment allows the 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 treatment will complicate the condition and make future rehabilitation more difficult.

I have read the above information about chiropractic treatment. I consent to chiropractic treatment from an Allen Family Wellness Doctor including joint adjustment or manipulation, mobilization to the joints of my spine, (neck and back), pelvis and extremities (shoulder, upper and lower limbs). I intend this consent to apply to all my present and future treatments at this clinic.

Signature of Patient/Legal Guardian

Date

Patients Printed Name

Legal Guardian's Printed Name

CONSENT TO X-RAY

I hereby grant Allen Family Wellness LLC permission to perform an x-ray evaluation as needed. I understand that x-rays are being performed to locate vertebral subluxations and not to diagnose or treat any other disease or condition.

Signature (parent if minor)

Date

Consent to evaluate and adjust a minor child

I, _____, being the parent or legal guardian of _____ have read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and I authorize Allen Family Wellness and their staff to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature

Date