Date:_____

PATIENT APPLICATION SURVEY

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

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

Email Address: _____ Cell Phone: ( ) _____

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

Names of Children:_____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so. When:_____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: _____Arm _____Leg _____Does not radiate Is this condition getting worse? _____

How often do you experience these symptoms during the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: _____Work ____Sleep _____Hobbies _____Daily Routine Explain_____

Have you experienced this condition before? ☐ Yes No If so, please explain:_____

Who have you seen for this?_____ What did they do?_____ How did you respond?_____

(office use only)

_____

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EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visit: _____

How did you respond? _____

Did your previous Chiropractor take before & 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

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

Explain: _____

The most common postural weakness is Forward Head Syndrome (head & neck starting to bend forward and progressively moving downward weakening your whole body.) Even less severe forms of this posture can cause many adverse effects 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 ☐

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 Pilaties Swimming _____

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

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

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

Do you take any 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 vertebra 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. Those misalignments are called subluxations (sub-lux-a-shins). 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 affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck progressively moving down your spine weakening the entire body). Please check any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

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

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbance
- ☐ Coldness in hands
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent colds/Flue
- ☐ Low Energy/ Fatigue
- ☐ TMJ/Pain/Clicking

Explain_____

_____

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations in your neck will weaken the nerves to the heart and lungs, and affecting these parts of your body. Do you experience . . . ?

- ☐ Heart Palpitations
- ☐ Heart attack/Angina
- ☐ Shortness of Breath
- ☐ Recurrent Lung Infection/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Upper Back pain
- ☐ Pain on deep Inspiration/Expiration

THORACIC SPINE (MID BACK)

Postural distortions from subluxations in your neck will weaken the nerves into your ribs/chest and upper digestive tract, and affecting these parts of your body. Do you experience . . . ?

- ☐ Mid Back Pain
- ☐ Pain into your rib/chest
- ☐ Indigestion/Heartburn
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Reflux
- ☐ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in your neck will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience . . . ?

- ☐ Pain into your hip/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Constipation/ Diarrhea
- ☐ Weakness/ Injuries in your hips/knees/ankles
- ☐ Recurrent bladder infections
- ☐ Muscle cramping in your legs/feet
- ☐ Menstrual irregularities/cramping (females)
- ☐ Low back pain
- ☐ Frequent/difficulty urinating
- ☐ Sexual dysfunction

Please list any health conditions not mentioned: _____

Please list any medication currently taking and their purpose: _____

Please list all past Surgeries:_____

Please list all previous accidents and falls:_____

(office use only)

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 toward the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/ reduce the vertebral subluxations complex. It is important that each person understand the objective and the method that will be used to obtain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic methods are by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

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

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjustments to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Dohrmann Family Chiropractic for x-rays, is for examination only and the x-rays will remain the property of this office. Being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Dohrmann Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments, and other chiropractic procedure, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or/other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustment and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health. I understand the I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for service rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there is some risk to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. 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 spine structure conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor specific recommendations at this clinic that I will not receive full benefit from the program offered, and that if I terminate my care prematurely that all fee 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. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I,_____, have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature _____ Date _____(*if under age 18*) Parent's signature

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctor office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claim and that I am ultimately held responsible for any unpaid balance. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature _____ Date _____(*if under age 18* Parent's signature)

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify to the best of my knowledge I am not pregnant and the above doctor and his /her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray could be hazardous to an unborn child. Date of last menstrual period _____.

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____