PATIENT APPLICATION SURVEY

Date: _____

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

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

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____/_____/_____ 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? ☐ Yes ☐ No

How often do you experience these symptoms throughout 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? _____

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 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

Explain: _____

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 and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects 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 No

HEALTH LIFESTYLE

Date: _____

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 _____

Do you smoke? Yes No How much? _____

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

Do you drink coffee? Yes No How many cups / 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 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 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 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...?

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ 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 (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...?

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks/Angina
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness Of Breath
- ☐ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

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

- ☐ Mid Back Pain
- ☐ Pain Into Your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

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

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

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: _____

FAMILY HEALTH HISTORY

Have any of family members ever been diagnosed with the following:

- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Broken bones/fractures
- ☐ Pneumonia
- ☐ Whooping Cough
- ☐ Thyroid
- ☐ Arthritis
- ☐ Varicose veins
- ☐ Circulatory problems
- ☐ Heart Disease
- ☐ Epilepsy/seizures
- ☐ Metal Implants
- ☐ Appendectomy
- ☐ ectomy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Small Pox
- ☐ Neurological problems
- ☐ Stroke
- ☐ Cancer
- ☐ Migraine Headaches
- ☐ Infectious disease
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Influenza
- ☐ Lumbago
- ☐ Lung Disease
- ☐ Heart Murmur
- ☐ Osteoporosis
- ☐ Gall bladder
- ☐ Hernia
- ☐ Anemia
- ☐ Measles
- ☐ Pleurisy
- ☐ Eczema

AUTHORIZATION TO CARE

I do hereby authorize the doctors of Village family chiropractic to administer such care that is necessary for my particular case. This care may include consultation, physical examination, x-ray examination, spinal adjustments, or any other procedure that falls within the chiropractic scope of practice and is advisable, and necessary for my healthcare.

Furthermore I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustments, various physical rehabilitative modalities and/or rehabilitative exercises for the purpose of postural restoration, restoration of spinal biomechanical motion, neurological function and the reduction or elimination of objective findings and subjective complaints obtained via physical examination, x-ray and oral consultation.

I understand that 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 services rendered will be charged and that I am responsible for this fee whether symptomatic results are obtained or not.

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 treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees 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.

Patient's Name Printed	Date	Patient's signature	Date
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor		Date

Insurance information

I clearly understand that all insurance coverage, whether accident, work related or general coverage is an arrangement between my insurance carrier, village family chiropractic and myself. I authorize village family chiropractic to submit medical claims to my insurance carrier and receive payments on my behalf from my insurance carrier. I understand that if my insurance carrier denies payment that I am ultimately responsible for the unpaid balance unless collection of such payments is forbidden by village family chiropractics contractual relationship to my insurance carrier.

Patient's Name Printed	Date	Patient's signature	Date
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor		Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

Village Family Chiropractic

I, _____ have read a copy of **Village Family Chiropractic** notice of privacy practices.

_____ _____

Signature of patient or parent or legal guardian Date