APPLICATION FOR CARE AT GARDEN CITY CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ⚪ Male ⚪ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ⚪ Single ⚪ Married Do you have insurance? ⚪ Yes ⚪ No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is:	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ⚪ AM ⚪ PM ⚪ mid-day ⚪ late PM

How long does it last? ⚪ It is constant **OR** ⚪ I experience it on and off during the day **OR** ⚪ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ⚪ No ⚪ Yes **If yes,** when? _____ by whom?

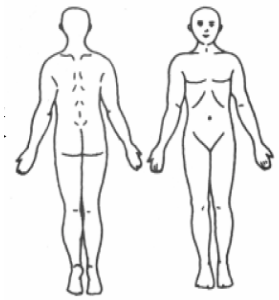
_____

How long were you under care? _____ What were the results? _____

Name of previous chiropractor: _____ □ **N/A**

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME: _____ Date: _____

_____ _____ _____

_____ _____ _____

PATIENT'S NAME: _____ Date: _____

Is your problem the result of ANY type of accident? ◯ Yes ◯ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ◯ No ◯ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ◯ No ◯ Yes **If yes,** please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results. ◯ Favorable ◯ Unfavorable Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had ___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ◯ No ◯ Yes **If yes,** whom?
◯ grandmother ◯ grandfather ◯ mother ◯ father ◯ sister(s) ◯ brother(s) ◯ son(s) ◯ daughter(s)
Have they ever been treated for their condition? ◯ No ◯ Yes ◯ I don't know

2. Any other hereditary conditions the doctor should be aware of? ◯ No ◯ Yes:

_____

SOCIAL HISTORY

1. Smoking: ◯ cigars ◯ pipe ◯ cigarettes How often? ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never
2. Alcoholic Beverage: consumption occurs ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never
3. Recreational Drug use: ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never
4. Hobbies - Recreational Activities - Exercise Regime: How does your present problem affect? (See Activities of Life form)

I hereby authorize payment to be made directly to [INSERT PRACTICE NAME], for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [INSERT PRACTICE NAME] for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Sit to Stand	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Climb Stairs	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Pet Care	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Extended Computer Use	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Lift Children/Groceries	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Read/Concentrate	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Getting Dressed	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Shaving	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Sexual Activities	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Sleep	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Static Sitting	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Static Standing	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Yard work	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Walking	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Washing/Bathing	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Sweeping/Vacuuming	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Dishes	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Laundry	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Garbage	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Driving	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform
Other: _____	⚪ No Effect	⚪ Painful (can do)	⚪ Painful (limits)	⚪ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

_____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed

_____
Doctor's Signature

_____ - _____ - _____
Date Form Reviewed

PATIENT'S NAME: _____ Date: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disabilty	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT'S NAME: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) (Date)

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at [Insert Practice Name] have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

□ The first day of my last menstrual cycle was on ____-____-____ (Date)

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with

PATIENT'S NAME: _____ Date: _____

exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF GARDEN CITY CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS..

_____	_____
PRINT YOUR NAME HERE	**DATE**
_____	_____
SIGNATURE	**YOUR AGE**

DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13		☐1/20	15
☐14-15		☐**1/15**	20
☐16-17		☐1/10	30
		☐2/15	40

MA 200 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/10	20
☐24-25		☐2/10	30
☐26-27		☐2/10	40
☐28-29		☐1/4	50
☐30-31		☐4/10	75
☐32-33		☐1/2	90
☐34-35		☐8/10	120
☐36-37		☐1	150

MA 200 Size 14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19		☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 200 Size 14x17

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐**1/10**	20
☐16-17		☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 200 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐88	☐1/4	40
☐30-31	☐88	☐3/10	50
☐32-33	☐88	☐2/5	70
☐34-35	☐88	☐1/2	90
☐36-37	☐90	☐3/5	120
☐38-39	☐92	☐4/5	160
☐40-41	☐94	☐1	200
☐42-43	☐96	☐1 1/2	
☐ 44-45	☐ 98	☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐80	☐2/10	40
☐22-23	☐80	☐1/4	50
☐24-25	☐80	☐4/10	75
☐26-27	☐80	☐1/2	90
☐28-29	☐80	☐4/5	120
☐30-31	☐80	☐4/5	150
☐32-33	☐80	☐4/5	120
☐34-35	☐80	☐1	170
☐36-37	☐80	☐1	210
☐38-39	☐80	☐1 1/2	
☐40-41	☐82	☐2	
☐42-43	☐ 82	☐2	
☐ 44-45	☐ 84	☐3	

MA 200 Size 14x17

Notes: _____

CA Initials: _____

PATIENT'S NAME: _____ Date: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Garden City Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- ⚪ Spouse Name: _____
- ⚪ Significant Other Name: _____
- ⚪ Parent/Legal Guardian Name: _____
- ⚪ Child(ren) Name(s): _____
- ⚪ Any Specified Person Name: _____
- ⚪ Information is not to be discussed with or released to anyone.

Restrictions:

- ⚪ No Restrictions
- ⚪ Only discuss my appointment time with the above-named individual(s).
- ⚪ Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- ⚪ Only discuss the health treatment rendered to me with the above-named individual(s).

I understand I may terminate this consent at any time by giving written notice to [Insert Practice Name]. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____