apex family chiropractic

**TEAM MEMBERS ONLY**

**Today's Date**: _____-_____-_____

**PM File Number**: _____

# New Practice Member Application

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Do you have Insurance: ☐ Yes ☐ No Have you served in the military: ☐ Yes ☐ No

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children, ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

***Whom may we thank for referring you to this office?*** _____

## HISTORY OF CURRENT HEALTH CONCERNS

### List the Health Concerns that brought you into this Office

| | List Concerns According to Severity | Rate of Severity 0 = No Pain 10 = Unbearable | When did this problem start? | Have you had this problem before? If so, when? | Did the problem begin with an injury? | Are symptoms constant (C) or intermittent (I)? |
|---|---|---|---|---|---|---|
| Primary | _____ | _____ | _____ | _____ | _____ | _____ |
| Second | _____ | _____ | _____ | _____ | _____ | _____ |
| Third | _____ | _____ | _____ | _____ | _____ | _____ |
| Fourth | _____ | _____ | _____ | _____ | _____ | _____ |

Have you ever seen other doctors for these conditions? □ Yes □ No Who? _____

If Yes: □ Chiropractor □ Medical doctor □ Other_____

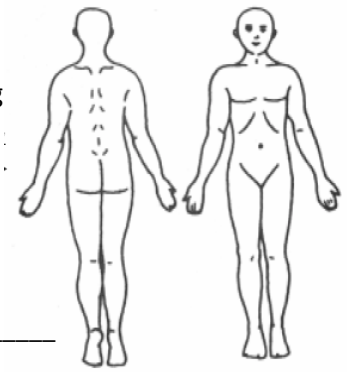
Name of Previous Chiropractor: _____ ☐ **N/A** Name of MD: _____ ☐ **N/A**

When?_____ Results?_____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

What relieves your symptoms? _____ What makes your symptoms feel worse? _____

**PLEASE MARK** the areas on the Diagram with the following **LETTERS** to describe your symptoms:
**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling
**Indicate where pain travels with arrows**



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

_____

_____

List **PRESCRIPTION** & **NON-PRESCRIPTION DRUGS** you take, and provide a **REASON** for taking each one (i.e. Zantac – Allergies):

_____

_____

## Please Mark "**P**" For in The **Past** OR Mark "**C**" For **Currently** Have:

__Acid Reflux
__ADD/ADHD
__Allergies
__Anxiety
__Arthritis/Joint Pai
__Asthma
__Bed Wetting
__Bladder Issues
__Cancer
__Chronic Colds
__Constipation
__Depression
__Diabetes
__Diarrhea
__Difficulty Breathir
__Digestive Issues
__Double/Blurry Vision
__Ear Infections
__Epilepsy/Convulsions
__Fatigue
__Fibromyalgia
__Food Sensitivity
__GERD/Gastric Reflux
__Headaches
__Hearing Loss
__Heart Attack
__Heart Issues
__High/Low Blood Pressure
__Infertility
__Irritability
__Kidney Issues
__Menstrual Issues
__Migraines
__Muscle Spasms
__Muscle Weakness
__Nausea
__Nervousness
__Numb/Tingling in Arms/Hands
__Numb/Tingling in Legs/Feet
__Stroke
__Plantar Fasciitis
__Poor Circulation
__Poor Posture
__Prostate Issues
__Ringing in the Ears
__Shortness of Breath
__Sinus Issues
__Skin Problems
__Sleep Issues
__Spinal Bone Fracture
__Spinal Surgery
__Sports Injury
__Stiffness
__Thyroid Issues
__Tight/Sore Muscles
__Tremors
__Ulcers
__Weight Loss/Gain
__Vertigo

Pacemaker: Y N

**PAIN**
__Arm
__Chest
__Foot
__Hip/Leg
__Jaw/TMJ
__Knee
__Lower Back
__Mid Back
__Neck
__Shoulder
__Stomach
__Upper Back
Other_____
_____
_____

## QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

*Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.*

***EXAMPLE***: No pain _____ Worst possible pain

Back pain Headaches

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

**1. How would you rate your pain RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

**2. What is your typical or AVERAGE pain?**

0 1 2 3 4 5 6 7 8 9 10

**3. What is your pain level at its BEST?**

0 1 2 3 4 5 6 7 8 9 10

**What percentage of your hours awake is your pain at its <u>best</u>?** _____%

**4. What is your pain level at its WORST?**

0 1 2 3 4 5 6 7 8 9 10

**What percentage of your hours awake is your pain at its <u>worst</u>?** _____%

## PAST HISTORY

Have you ever been in an auto accident? ☐ Yes ☐ No List all:_____

_____

**Please list any additional Injuries and/or Health Concerns, that have NOT been previously mentioned, in the chart below:**

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|
| **INJURIES/TRAUMA →** | | | |
| **SURGERIES →** | | | |
| **CHILDHOOD DISEASES →** | | | |
| **ADULT DISEASES →** | | | |

## SOCIAL HISTORY

☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

**1. Smoking**: ☐ Cigars ☐ Pipe ☐ Cigarettes

**2. Alcoholic Beverage**:

**3. Exercise**:

**4. Have you consumed any caffeine or products with caffeine in the past 48 hours?** ☐ Yes ☐ No

## 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 |
| Concentration (Reading) | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dressing | ☐ 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 ANY OTHER RESTRICTED ACTIVITY: | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |
| _____: | _____ | _____ |

## GOALS

What are your top 3 health/life goals?

| |
|---|
| **1.** |
| **2.** |
| **3.** |

**FAMILY HISTORY**

***This form is to assist Dr. Ben & Team Apex by providing past health history information for their review.***

| CONDITION | SPOUSE | SON | DAUGHTER | MOTHER | FATHER |
|---|---|---|---|---|---|
| Headaches | | | | | |
| Neck Pain | | | | | |
| Jaw/TMJ Pain | | | | | |
| Shoulder Pain | | | | | |
| Back Pain | | | | | |
| Hip/Leg Pain | | | | | |
| Arthritis/Joint Pain | | | | | |
| Ear Infections | | | | | |
| Hearing Loss | | | | | |
| Dizziness | | | | | |
| Loss Of Energy | | | | | |
| Nervousness | | | | | |
| Blurred/Double Vision | | | | | |
| Anxiety | | | | | |
| ADD/ADHD | | | | | |
| Depression | | | | | |
| Allergies | | | | | |
| Sinus Issues | | | | | |
| Thyroid Problems | | | | | |
| Asthma | | | | | |
| Breathing Problems | | | | | |
| Heart Problems | | | | | |
| High/Low Blood Pressure | | | | | |
| Stomach Problems | | | | | |
| Bed Wetting | | | | | |
| Infertility | | | | | |
| Sciatica | | | | | |
| Fibromyalgia | | | | | |
| Poor Posture | | | | | |
| Sleep Problems | | | | | |
| Stroke | | | | | |
| Cancer | | | | | |
| Heart Disease | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | | | | | |
| Arthritis | | | | | |
| Alzheimer's | | | | | |

## X-RAY AUTHORIZATION

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. Digital x-rays will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Apex Chiropractic does 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.*

_____ _____ - _____ - _____

**Printed Name** **Date of Birth**

_____ _____ - _____ - _____

**Signature** **Date Completed**

***FEMALES ONLY:*** *To the best of my knowledge,* ***I BELIEVE I AM NOT PREGNANT*** *at the time the x-rays are taken at Apex Chiropractic.*

**Signature**: _____ **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 physician's 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 Completed**

**See back →**

## INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Benjamin Sevlie D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____

**Printed Name**

_____ _____ - _____ - _____

**Signature** **Date Completed**

## CHILD/MINOR INFORMED CONSENT FOR CHIROPRACTIC CARE

***If This Health Profile Is For A Child/Minor, Please Fill Out And Sign Below***
***Written Consent For A Child***

**Name of practice member who is a minor/child**: _____

I authorize Dr. Benjamin Sevlie and any and all Apex Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Apex Chiropractic.

**Guardian Signature: _____ Date:** _____ - _____ - _____

**Relationship to Child/Minor: _____**