HARBOR CHIROPRACTIC
&
PHYSICAL THERAPY

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient , we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

Patient Name

_____

Date Completed

Patient Information

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

Occupation: _____ Employer Name: _____

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

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ☐ Yes ☐ No If yes, when: ____/____/____

**If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? ____/____/____ Are they: ☐ Constant ☐ Intermittent ☐ Activity-related

Are they getting worse? ☐ Yes ☐ No Do they interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ☐ Yes ☐ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? ☐ Yes ☐ No

If yes, explain: _____

Have you been treated for this? ☐ Yes ☐ No When were you last treated? ____/____/____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic and Physical Therapy?

Have you seen a DOCTOR before? ☐ Yes ☐ No Who? _____

Reason for visit(s): _____

Did your previous DOCTOR take 'before' and 'after' x-rays? ☐ Yes ☐ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ☐ Yes ☐ No Did they recommend a Home Health Care program? ☐ Yes ☐ No

If yes, what? _____ How long were you treated? _____ Last treatment: ____/____/____

How did you respond? _____

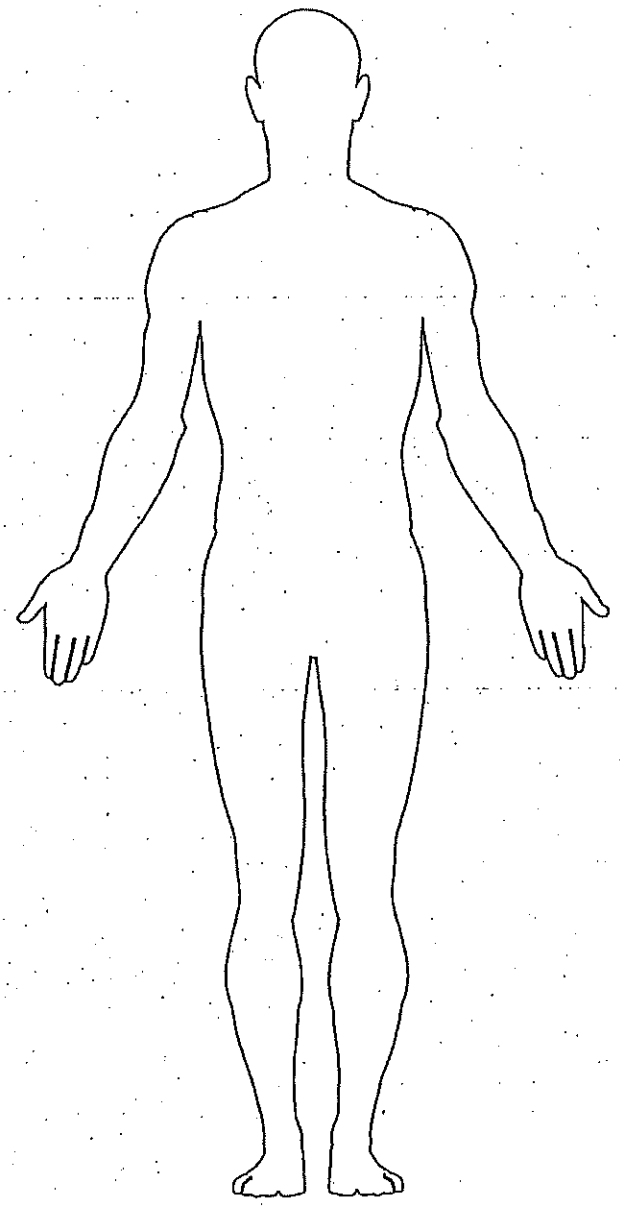
Are you aware of any poor posture habits? ☐ Yes ☐ No Are there any health problems in your family?

If yes, explain: _____

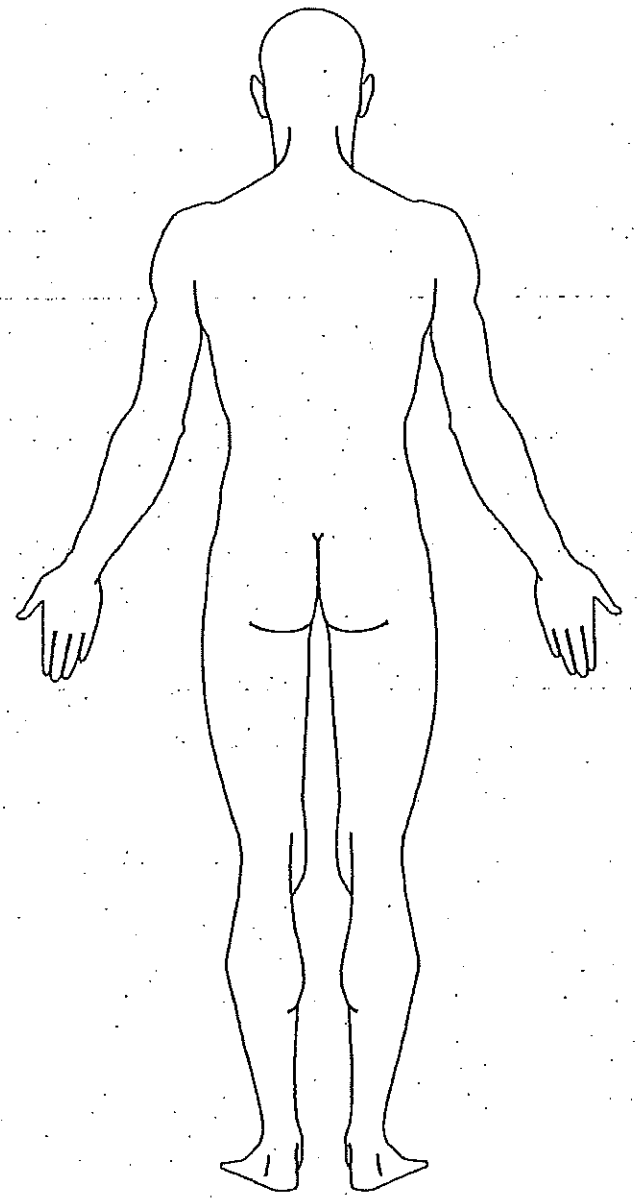
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Health & Lifestyle

Do you exercise? ☐ Yes ☐ No How often? _____ day(s) per week; Other: _____

What activities? ☐ Walking ☐ Running/Jogging ☐ Weight Training ☐ Cycling ☐ Yoga ☐ Pilates ☐ Swimming ☐ Other: _____

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

Do you drink alcohol? ☐ Yes ☐ No How much? / How often? _____

Do you drink coffee? ☐ Yes ☐ No How much? / How often? _____

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

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain	____ Headaches	____ Sinusitis
____ Pain in shoulders/arms/hands	____ Dizziness	____ Allergies/Hay fever
____ Numbness/tingling in arms/hands	____ Visual disturbances	____ Recurrent colds/Flu
____ Hearing disturbances	____ Coldness in hands	____ Low Energy/Fatigue
____ Weakness in grip	____ Thyroid conditions	____ TMJ/Pain/Clicking

Please explain: _____

_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

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

Please explain: _____

_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Diabetes
____ Hypoglycemia/Hyperglycemia
____ Tired/Irritable after eating or when not having eaten for a while

Please explain: _____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

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

Please explain: _____

OTHER

Please list any health conditions not mentioned: _____

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

Please list any surgeries (include type of surgery and date it was performed): _____

Family Health History

Have any of your family members ever been diagnosed with the following *(please indicate "Y" for You, and "O" for Other than you, or both if applicable)*:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

Pregnancy Release

This is to certify that 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 can be hazardous to an unborn child.

Date of last menstrual cycle: _____/_____/_____

Patient's Signature _____ Date _____/_____/_____

Authorization of Care

I authorize and agree to allow the doctor and/or his/her designated staff to take x-rays and work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his/her staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date _____/_____/_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____/_____/_____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage therapy, physiotherapy and diagnostic X-rays and diagnostic testing, on me (or on the patient names below, for whom I am legally responsible) by the Doctor named below and/or other licensed Doctors who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc 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 upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also has an opportunity to ask questions about its content, and by signing below I agree to the above-names 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.

Provider Signature _____ Date ____/____/____

Patient Signature _____ Date ____/____/____

Witness Signature _____ Date ____/____/____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's 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 claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ☐ Yes ☐ No

Patient's Signature_____ Date ____/____/____

Signature of Person Authorizing Care (If different from patient):

_____ Date ____/____/____

Relationship to Insured _____ Date of Birth ____/____/____

Employer _____

Primary Insurance Company_____ Policy#_____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: ____-____-____

Secondary Insurance Company_____ Policy#_____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: ____-____-____