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

# APPLICATION FOR CARE AT NEW LIFE CHIROPRACTIC

Today's Date: _____ HRN: _____

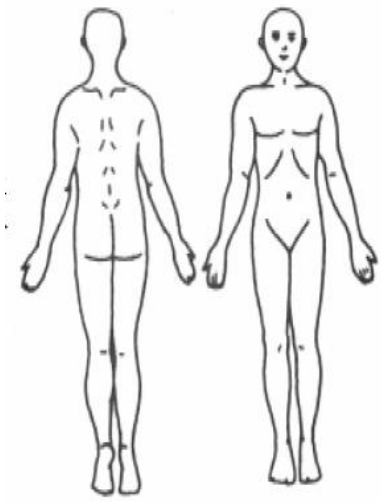
## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____Mobile Phone:_____
Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____
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: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
**Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Third** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
**Fourth** complaint: : 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?_____**
**C**ondition(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 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



Using the body chart above, indicate the region(s) of your complaint using the following symbols:

| | |
|---|---|
| Ache x x x x x | Burning / / / / / / |
| Pins & Needles o o o o | Stabbing + + + + |
| Throbbing = = = = | Other - - - - - - |

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

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: _____
_____
_____
_____
_____
_____

| LIST RESTRICTED ACTIVITY: | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|
| _____: | _____ | |
| _____: | _____ | |
| _____: | _____ | |
| _____: | _____ | |

## 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. _____ _____

**PAST HISTORY (CONT'D)**

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 a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** 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 RECEIVED | BY WHOM |
|---|---|---|---|
| **INJURIES** → | | | |
| **SURGERIES** → | | | |
| **CHILDHOOD DISEASES**→ | | | |
| **ADULT DISEASES** → | | | |

## 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 the following, See pg 2- Activities of Life

## 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: _____

I hereby authorize payment to be made directly to New Life Chiropractic 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 New Life Chiropractic 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: _____ HR#: _____ ___/___/___** **JDD,DC 5/2011**

New Life Chiropractic

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: | | | |
|---|---|---|---|---|
| Carrying/lifting Groceries | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Sit to Stand | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Climbing Stairs | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Pet Care | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Extended Computer Use | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Household Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Lifting Children | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Reading/Concentration | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Bathing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |
| Dressing | ☐ 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 |
| Other: _____ | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (limits) | ☐ Unable to Perform |

**Please mark P** for in the **Past, C** for **Currently** have and **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) |

**List Prescription & Non-Prescription drugs you take**:_____

_____

_____

Patient signature: _____ Today's Date: ___/___/___

**Patient Name**_____ Date_____

# INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field_____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

# INITIAL NUTRITIONAL PROFILE

1. Have you tested with high triglycerides or high cholesterol? (Y / N) Values?_____
2. Have you tested with high blood pressure? (Y / N)
3. Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)
4. Do you eat breakfast daily from Monday to Friday? (Y / N) _____
5. How many days per week do you skip one meal? (0) (1) (2) (3) (4+)
6. How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)
7. How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)
8. How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)
9. Do you regularly drink (1 or more per day) any of the following? (circle all that apply)
   Diet Soda Coffee Juice Milk Soda Alcohol
10. Please list any supplements you take regularly:

    _____

    _____

# INITIAL FITNESS PROFILE

1. How many times per week do you exercise?
   Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk Low Impact (Yoga, etc.) ___Hours ___Days/Wk
2. What is your target weight? _____What is your current weight? _____
3. How willing are you to change these things to reach your health goals? ***(Scale of 1-10)*** _____

# INITIAL TOXICITY PROFILE

1. Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)
2. Have you ever noticed mold growing in your home or your place of work? (Y / N)
3. Does your home, work, school, or car have damp or mildew smell? (Y / N)
4. Have you received a full standard profile of vaccinations? (Y / N)
5. Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)
6. Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)
7. Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

# INITIAL STRESS PROFILE

1. Do you get an average of 8 hours of sleep per night (Y/N)
2. Do you average less than 7 hours of sleep per night (Y/N)
3. Do you ever take pills to go to sleep or relax (Y/N)
4. Do you often feel short on time and procrastinate on projects? (Y / N)
5. Do you experience feelings of anxiety about completing tasks? (Y / N)
6. Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)
7. Do you rely more on your memory than a planner and action list to get things done? (Y / N)
8. Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

**Doctor Signature** _____**Date**_____ JDD, DC 5/2011

# 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 very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at New Life Chiropractic 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.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

**REGARDING:** X-rays/Imaging Studies:

**FEMALES ONLY** → *Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist 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 exposure to x-rays. After careful consideration, I do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

**JDD,DC 5/2011**

# New Life Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

**PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

**YOUR RIGHTS:**

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

**COMPLAINTS:**

If you wish to make a formal complaint about how we handle your health information, please call the office staff at (615) 221-8033 If we are unavailable, you may make an appointment to meet with any of us within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of New Life Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

**JDD,DC 5/2011**

***New Life Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….***

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

| Patient's Name | DOB | HR# |
|---|---|---|

| Patient signature | Date |
|---|---|

| Witness | Date |
|---|---|



**JDD,DC 5/2011**