New Practice Member Application (Adult)

Name: ________________________________ Date of Birth: ___ /___ /____ Age: ______ Male / Female
Address: ________________________________ City: ___________________ State: _____ Zip: __________
Phone Number: ________________________________ Mobile/Home
Email: _____________________________________ Preferred Contact: Email / Text Message / Phone Call
Occupation: ________________________________ Employer's Name: ____________________________
Marital Status: Single/ Married / Divorced / Widowed Spouse's Name: ____________________________
Number of Children: _______ Names, Ages, & Gender: ____

____

Whom may we thank for referring you? ____

Health Concerns That Brought You Into Our Office

Health Concerns Listed According to Severity:	Rate of Severity: 0 = No Pain 10 = Unbearable	When did this problem start?	Did the problem begin with an injury?	Are the symptoms constant (C) or intermittent (I)?
1. ____________	____________	____________	____________	____________
2. ____________	____________	____________	____________	____________
3. ____________	____________	____________	____________	____________
4. ____________	____________	____________	____________	____________

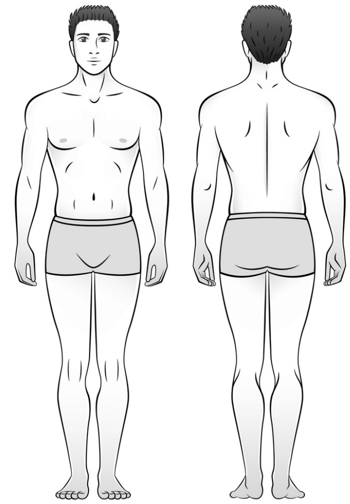
Have you seen other doctors for these conditions? Yes / No
If Yes: Chiropractor / Medical Doctor / Other: _____________________________
Who?: ____________________________ When?: ___________________ Results?: __________________

Please Mark Your Current Health Concerns:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing
___ Stroke	___ Cancer	___ Heart Attack	___ Diabetes	___ Arthritis

Are you pregnant? Yes / No If yes, when is your due date? ________________

Please Mark Areas on the Diagram with the Following Letters to Show Symptoms



A = Aching
D = Dull
R = Radiating
B = Burning
N = Numbness
T = Tingling
S = Sharp/Stabbing

What relieves your symptoms?

____

What makes your symptoms feel worse?

____

When is the problem(s) at its worst? AM PM MId-Day Late PM

List all surgical operations & years: ______________________________

List any other injuries to your spine, minor or major, that the doctors should know about:

____

List all over the counter & prescription medications you are taking & the reasons for each:

____

Have you ever been in an auto accident? Yes / No If Yes, When?: ______________________________

Have you ever been knocked unconscious? Yes / No Fractured a Bone? Yes / No

If Yes to either of the above, please describe: ______________________________

Other trauma: ______________________________

Social History (Circle Frequency)

1. Smoking:	Never	1-2x/week	3+ days/week	Daily
2. Alcohol:	Never	1-2x/week	3+ days/week	Daily
3. Exercise:	Never	1-2x/week	3+ days/week	Daily

Quadruple Visual Analogue Scale (QVAS)

Please circle the 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.

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

4. What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

Daily Activities

Please circle how your current condition is affecting your ability to carry out activities of your daily life:

Activity:	**Effect:**			
Sitting to Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Climbing Stairs	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	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
Sleeping	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Prolonged Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Prolonged Standing	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
Yard Work	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Exercising	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Turning Head	No Effect	Painful (can do)	Painful (limits)	Unable to Perform

Daily Activity Goals

Please list the top 3 activities from above that you'd like to see improvements in while under care:

ACTIVITY	**CURRENT ACTIVITY LEVEL**	**GOAL ACTIVITY LEVEL**
Example: Sleeping	*2-4 Hours Per Night*	*6-8 Hours Per Night*
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Family Health History

Please check any conditions that members of your family have or are currently experiencing.

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					
Stomach Problems					
High/Low Blood Pressure					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Alzheimer's					

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 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.

Name: ____

Signature: ____ Date: ______________

If This Health Profile is for a Minor/Child, Please Fill Out and Sign Below
Written Consent for a Child

Name of practice member who is a minor/child: ___________________________ DOB: __________

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

Name of Guardian: __________________________ Relationship: ____________________

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. Conduct normal health care 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 health care 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.

Name: ____

Signature: ____ Date: ______________

X-Ray Authorization

As your health care 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 on a CD 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 doctors of Edified 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.

Name: ____ DOB: ______________

Signature: ____ Date: ______________

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

Signature: ____ Date: ______________