AURORA CHIROPRACTIC

Patient Application

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line)

Section 1: Patient Information Appt. Date: _____/_____/_____

Name: _____ Middle Initial: _____ Age: ____

Preferred Name: _____ ☐Male ☐Female Date of Birth: ___ /____ /_____

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Provider: _____

Email: _____

SSN #: _____ ☐Married ☐Single ☐Divorced ☐Widow

Employer & Occupation: _____

Job Description: _____

Name of Spouse & Employer: _____

Names & Ages of Children: _____

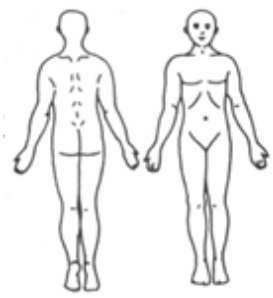
_____

Who may we thank for referring you? _____

Section 2: History of Complaint

Health Concerns:	Rate Severity 1 = mild 10 = unbearable	When did it start?	Have you had it before, when?	Did the problem begin with an injury	Is it consistent Or intermittent?
Example: Low back pain	***6***	***1/10/15***	***1/15/13***	***shoveling snow***	***intermittent***
1.					
2.					
3.					

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



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Whom have you seen in the past for this condition? _____

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

Continued on back

Section 3: Current Health Problems (Please Circle)

This allows the Doctor to have an overall view of your health status

Dizziness	Asthma	Menstrual Disorder	Chronic Fatigue
Headaches/Migraines	Chest Pain	Irritable Bowel	Lupus
Vertigo	Heart Disease	Sciatica	Fibromyalgia
Ear Infections	High Blood Pressure	Numbness in Legs	Disc Problems
Nausea	Low Blood Pressure	Numbness in Feet	Arthritis
TMJ	Breathing Difficulty	Low Back Pain	Frequent Colds
Anxiety	Ulcers	Bladder Problems	Frequent Flu
Chronic Sinusitis	Stomach Disorders	Hip Pain	Emotional Disorder
Throat Issues	Kidney Problems	Leg Pain	Mental Disorder
Thyroid Problems	Mid-back Pain	Knee Pain	Epilepsy
Numbness in Arms	Liver Disease	Infertility	Nervousness
Numbness in Hands	Gastric Reflux	Bedwetting	Other: _____
Shoulder Pain		Frequent Urination	_____
Arm Pain		Menopausal Problem	

Section 4: Past Health History

Circle any condition you have now or have had: Stroke Cancer Heart disease Spinal surgery Seizures Spinal bone fracture Broken bone Dislocation Cerebral vascular disease Scoliosis Diabetes Knocked unconscious Tumors Rheumatoid arthritis Osteoarthritis Cancer

Explain: _____

List all surgical operations and years: _____

When was your last auto accident? _____

Have you ever had previous chiropractic care (if so when and by whom)? _____

_____

Other trauma: _____

_____

List all medication and supplements: _____

_____

Section 5: Social Health 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: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Hobbies -Recreational Activities- Exercise Regime: _____

Section 6: Family Health 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) ☐ children

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: _____

_____

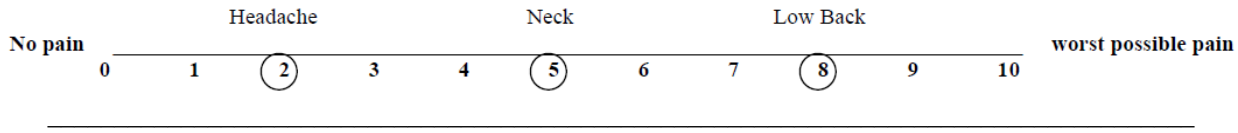
Section 7: Health Goals

	Health Goal	**Accomplish By**	**Significance of Goal**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Section 8: Quadruple Visual Analog Scale (QVAS)

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:



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

0 1 2 3 4 5 6 7 8 9 10

2. How would you rate your pain on **AVERAGE**?

0 1 2 3 4 5 6 7 8 9 10

3. How would you rate your pain **AT ITS BEST**?

0 1 2 3 4 5 6 7 8 9 10

4. How would you rate your pain **AT ITS WORST**?

0 1 2 3 4 5 6 7 8 9 10

Office Use Only

Current: _____ ***Goal:*** _____

Section 9: Activities of Daily Living

ACTIVITIES:				EFFECT:
Carry/Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Use the Computer	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Get Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Perform Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Perform House/Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Wash/Bath/Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Do Dishes/ Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
To Drive	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Section 10: Insurance Authorization:

I hereby authorize payment to be made directly to Aurora 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 Aurora 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**

Continued on back

Section 11: 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 risk 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 Aurora 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

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 therefore, 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

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.

Section 12: Notice of Privacy 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). . 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. I understand that this information can and will be used to:

1. Conduct, plan and direct 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.
4. Emergency - in the event of a medical emergency we may notify a family member
5. 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.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICE 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.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date