INSIDE-OUT FAMILY CHIROPRACTIC

New Practice Member Application

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Cell Phone_____ Home Phone _____ Cellular Provider_____

Email Address_____ Occupation_____

Employer's Name_____ Single / Married / Divorced / Widowed

Spouse's Name_____ Number of Children_____

Names, Ages, & Gender_____

Who may we thank for referring you? _____

List the health concerns that brought you into this office

Health Concern: List according to severity.↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
A: _____	_____	_____	_____	_____	_____
B: _____	_____	_____	_____	_____	_____
C: _____	_____	_____	_____	_____	_____
D: _____	_____	_____	_____	_____	_____

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

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ 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	___ Arthritis/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

Other: _____

INSIDE-OUT FAMILY CHIROPRACTIC

Please Mark "P" For In The Past OR "C" For Currently Have:

___Stroke ___Cancer ___Heart attack ____Spinal Surgery ____ Spinal Bone Fracture
___Scoliosis ___Diabetes ___Arthritis ___Seizures ____Other Conditions

List all surgical operations & years: _____

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

_____

List all over the counter & prescription medications you are on, & the reason for each:

_____

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? □ Yes □ No Explain_____

Fractured A Bone? □ Yes □ No Explain: _____

Other trauma: _____

Social History

1. Smoking: How often? □ Daily □ Weekends □ Occasionally □ Never
2. Alcohol: How often? □ Daily □ Weekends □ Occasionally □ Never
3. Exercise: How often? □ Daily □ Weekends □ Occasionally □ Never
4. Have you consumed any caffeine or products with caffeine in the past 48 hours? □ Yes □ No

Quadruple Visual Analogue Scale

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 listed on page one and indicate the corresponding letter above

EXAMPLE: No pain ___A_____B_____Worst possible pain

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? (How close to 0 does your pain ever get?)

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST? (How close to 10 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

Health Goals

Please list your two main health goals that you would like to achieve while under care in this office:

1. _____
2. _____

INSIDE-OUT
FAMILY CHIROPRACTIC

Family Health History

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	MOTHER	FATHER	SON	DAUGHTER
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					
Infertility					
Bed Wetting					
Sciatica					
Sleep Problems					
Stroke					
Fibromyalgia					
Poor Posture					
Alzheimer's					
Diabetes					
Heart Disease					
Cancer					

INSIDE-OUT
FAMILY CHIROPRACTIC

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

CIRCLE 3 activities that affect you the most on a day to day basis.

Climb Stairs

Walk

Run

Sleep

Dress

Carry Groceries

Pet Care

Drive Lift

Extended Computer Use

Household Chores

Read/Concentrate

Shaving

Sweep Vacuum

Dishes

Laundry

Yard Work

Static Standing

Static Sitting

INSIDE-OUT
FAMILY CHIROPRACTIC

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $20-$80.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $10-$50.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $25 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Juan Munoz DC. 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 patient. 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.

Signed_____ **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 (HIPPA). 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: _____

INFORMED CONSENT

You have a right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

THE NATURE AND PURPOSE OF CHIROPRACTIC

Chiropractic is predicated on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nerve system) of the body and how this relationship can affect the restoration and preservation of health. The following information is routinely furnished to all who consider Chiropractic care and treatment in this clinic. Adjustments are made by Chiropractors in order to correct spinal and extremity joint subluxations. One of the most common disturbances to the nerve system is the vertebral subluxation. This condition is where one or more vertebra in the spine is misaligned sufficiently to cause interference and/or irritation to the nerve system. The primary goal in Chiropractic health care is the removal of nerve interference caused by subluxation. A Chiropractic examination will be undergone which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiological examination (x-rays). The Chiropractic adjustment is the application of a precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which the Chiropractic adjustment is delivered. Chiropractic adjustments can be delivered by hand, but will be delivered using an instrument or other specialized equipment at Inside-Out Family Chiropractic.

CONSENT FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of Chiropractic care, the possible consequences of care, and the risks of care, including the risk that care may not accomplish the desired objective. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE INSIDE-OUT FAMILY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

_____

PRINT NAME HERE

_____ _____

SIGNATURE **DATE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE**, I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT INSIDE-OUT FAMILY CHIROPRACTIC.

_____ _____

SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **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: _____

I authorize Dr. Juan Munoz and any and all Inside-Out Family 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 Navigate Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to minor/child: _____