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Application for Care at Alexander 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 ☐Divorced ☐Widowed 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 **circling 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

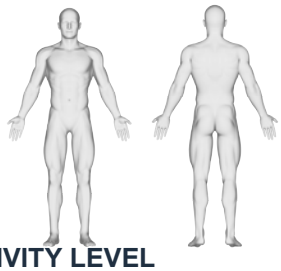
How did the injury happen?_____

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



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

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

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:

_____

_____

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: _____

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 or **N** for Never 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

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 Alexander 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 Alexander 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

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Patient Name_____ File#/HRN _____ 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 sitting, 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

Have you tested with high triglycerides or high cholesterol? (Y / N) Values?_____

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) _____

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or prepared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly:

_____
_____
_____

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INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular____Hours____Days/Wk Weight Training____Hours____Days/Wk

Low Impact (Yoga, etc.)____Hours____Days/Wk

What is your target weight?_____What is your current weight? _____

How willing are you to change any of these things to reach your health goals? (Scale of 1-10) _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have a damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received?_____(estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night? (Y / N)

Do you average less than 7 hours of sleep per night? (Y / N)

Do you ever take pills to go to sleep or relax? (Y / N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

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)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Doctor Signature_____Date_____JDD, DC 5/2011

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Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ File#_____

Daily Activities: Effects of Current conditions On Performance

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

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please mark P for in the Past, C for Currently have or N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfunction	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Digestive Problems
___ 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 Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritability	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

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Alexander 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 Personal Health Information. 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 means 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 the 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 apprise 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 Alexander Chiropractic at (251) 929 -2095. If we are unavailable, you may make an appointment with our receptionist to see Dr. Alexander 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

JDD,DC 5/2011

Patient initials: _____

Alexander Chiropractic's

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Alexander Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's 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 a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. 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	

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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 Alexander 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 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

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Administrative Notice of Office Policies

OUR OFFICE POLICIES

Welcome to Alexander Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Care**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctor at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted as patients at this office gain a greater understanding of the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness creates a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Alexander Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Thompson, Gonstead, and Pettibon. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely more supportive and helpful in making important decisions concerning treatment options.

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Note: Patient retains the above Notice of Office Policies and ALEXANDER CHIROPRACTIC retains the signature sheet.

Patient initials:_____-retaining pages 1 of 2

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

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