# APPLICATION FOR CARE AT AMPLIFY CHIROPRACTIC

Today's Date: _____ HR#: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Social Security #: _____ Have you served in the military? ○ Yes ○ No **If yes,** when? _____ to _____

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: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

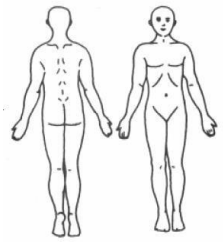
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____ by whom? _____

**PLEASE MARK** the areas on the body 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? _____

## Outcome Assessment Tool

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 (if you have multiple complaints): Headaches Neck Pain Low-Back Pain

No pain _____ worst possible pain

0 1 2 3 (4) 5 6 (7) 8 (9) 10

1. How would you rate your pain RIGHT NOW?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE PAIN?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S NAME: _____ HR#: _____ DATE: _____

## 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:

**P** for in the ***Past*** **C** for ***Currently*** have **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** | **PROVIDED BY WHOM** |
|---|---|---|---|
| **INJURIES** | | | |
| **SURGERIES** | | | |
| **CHILDHOOD DISEASES** | | | |
| **ADULT DISEASES** | | | |

## 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:_____

## 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

Continued on next page/reverse side

PATIENT'S NAME: _____ HR#: _____ 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: | | | |
|---|---|---|---|---|
| Carry Children/Groceries | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sit to Stand | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Climb Stairs | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Pet Care | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Extended Computer Use | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Lift Children/Groceries | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Read/Concentrate | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Getting Dressed | ○ 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 |
| 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 |
| Washing/Bathing | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Sweeping/Vacuuming | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Dishes | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Laundry | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Garbage | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Driving | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |
| Other: _____ | ○ No Effect | ○ Painful (can do) | ○ Painful (limits) | ○ Unable to Perform |

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

_____

_____

PATIENT'S NAME: _____ HR#: _____ Date: _____

## REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have

| | | | | |
|---|---|---|---|---|
| ___ 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 Disability | ___ 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) |

### Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and 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. 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 disclosed to carry out treatment, payment, or healthcare operation.

_____ _____ - _____ - _____

**Patient or Authorized Person's Signature** **Date Completed**

I hereby authorize payment to be made directly to Amplify 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 Amplify Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

**Patient or Authorized Person's Signature** **Date Completed**

PATIENT'S NAME: _____ HR#: _____ _____

# 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, 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 Amplify 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.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

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

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your xrays in our files. At your request, we will provide you with a copy of your x-rays. The medical records request is a one-time $15 charge. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Amplify Chiropractic does 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.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

**Female Patients Only:** To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT AMPLIFY CHIROPRACTIC.**

_____ ____/____/____

Patient or Authorized Person's Signature Date