PATIENT APPLICATION SURVEY

Name: ____ (Age) ______ Gender: M F

Home Address: ____ Home Phone: ( ) _______________________

City, State, Zip: ____ Work Phone: ( ) _______________________

Email Address: ____ Cell Phone: ( ) _______________________

Birth Date: ______ / ______ / _______ Social Security #: ________ - ______ - _________ Marital Status: S M D W

Names of Children: ____ Ages: ___________________

Occupation: ____ Employer Name: ______________________________

Spouse's Name: _________________________ Work Phone: ( ) _________________ Cell Phone: ( ) _______________________

Spouse's Employer: _______________________________________ Occupation: ____

How were you referred to this office? ____

Purpose of This Visit

Reason for this visit: ____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _______________________________________

Describe: ____

Please describe the pain & its location: ____

When did this condition begin? __________/_____/________ When did you first notice it? ___________________________________

Is this condition getting worse? ☐ Yes ☐ No Is this condition: ☐ Constant ☐ Comes & goes ☐ Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ____________________________________

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: ____

Who have you seen for this? ____________________________________ What did they do? ______________________________

How did you respond? ____

Experience with Chiropractic

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _________________________________ When? ____________________

Reason for visits: ____

How did you respond? ____

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No

Explain: ____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No

Explain: ____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

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Date: _______________

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: ___________________________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _______________

Do you smoke? Yes No How much? ____

Do you drink alcohol? Yes No How much / week? ____

Do you drink coffee? Yes No How many cups / day? ____

Do you take any supplements (i.e. vitamins, minerals, herbs)? ____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- Neck Pain
- Pain into your shoulders/arms/hands
- Numbness/tingling in arms/hands
- Hearing Disturbances
- Weakness In Grip
- Headaches
- Dizziness
- Visual Disturbances
- Coldness In Hands
- Thyroid Conditions
- Sinusitis
- Allergies/Hay fever
- Recurrent Colds/Flu
- Low Energy/Fatigue
- TMJ/Pain/Clicking

Explain: ____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- Heart Palpitations
- Heart Murmurs
- Tachycardia
- Heart Attacks/Angina
- Recurrent Lung Infections/Bronchitis
- Asthma/Wheezing
- Shortness Of Breath
- Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- Mid Back Pain
- Pain Into Your Ribs/Chest
- Indigestion/Heartburn
- Reflux
- Nausea
- Ulcers/Gastritis
- Hypoglycemia
- Tired/Irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- Pain into your hips/legs/feet
- Numbness/tingling in your legs/feet
- Coldness in your legs/feet
- Muscle cramps in your legs/feet
- Constipation / Diarrhea
- Weakness/injuries in your hips/knees/ankles
- Recurrent Bladder Infections
- Frequent/Difficulty Urinating
- Menstrual Irregularities/Cramping (females)
- Sexual Dysfunction
- Low Back Pain

Please list any health conditions not mentioned: ____

Please list any medications / surgeries: ____

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FAMILY HEALTH HISTORY

Have you or any of your family members ever been diagnosed with the following:

Diabetes	Varicose Veins	Neurological Problems	Lung Disease
Rheumatic Fever	Circulatory Problems	Stroke	Heart Murmer
High Blood Pressure	Heart Disease	Cancer	Osteoporosis
Kidney Disease	Epilepsy/Seizures	Mirgraine Headaches	Arthritis
Liver Disease	Metal Implants	Infectious Disease	Gall Bladder
Broken Bones/Fractures	Appendectomy	Rhematoid Arthritis	Hernia
Pneumonia	Polio	Tuberculosis	Anemia
Whooping Cough	Chicken Pox	Mumps	Multiple Sclerosis
Thyroid	Small Pox	Influenza	STD
		Lumago	Eczema

Other: ____

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spine column which interfere with the expression of the body's innate healing ability. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to faciliate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, pain, or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulse, resulting in the lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I, ______________________________ have read and fully understand the above statements.

All questions regarding doctors objectives pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

Signature ______________________________ Date ____________________

Consent to evaluate and adjust a minor child

I, ______________________________ being the parent or guardian of

______________________________ have read and fully understand the above terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

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INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. Pinnacle Chiropracticwill bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. A. Bastecki Chiropractic will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature____ Date________________________

Guardian or Spouse's Signature Authorizing Care________________________ Date________________________

I hereby authorize Pinnacle Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. ____ Policy#______________________

Address____ Phone # _____________________

Insured's Name____ Insured's SS# ____________________________

Relationship to Insured ____ Birthdate ______/______/______

Employer____

Who should receive charges on your account?

❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Auto Insurance

❑ Personal Health Insurance

Spinal Rehabilitation Consent and Waiver

Part of the treatment at Pinnacle Chiropractic involves specific spinal and physical exercise that may cause injury if used improperly. I, on behalf of myself, understand that there is an inherent risk of injury when choosing to participate in any physical rehabilitative activities. Use of the spinal and postural correction equipment is an integral part of my health and postural restoration process and will be instructed to me before I can start such activities. I, on behalf of myself, assume all risks of injury and illness that may result from such use. This includes use of the wobble chairs, traction equipment, treadmill, therapy ball chairs, vibratory platforms or any other equipment located in Pinnacle Chiropractic.

I on behalf of myself, do hereby fully release and discharge the Pinnacle Chiropractic and their employees from any and all liability, claims and causes of action from injuries or illness, damages or loss which I, on behalf of myself, may have or which may accrue to me on account of participation in all activities utilizing the facility.

Signature of Patient ________________________________ Date ___________

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HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES PINNACLE CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Pinnacle Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Pinnacle Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Pinnacle Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I __________________________ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

RADIOGRAPH CONSENT

I _________________________________ do hereby give my consent to allow Pinnacle Chiropractic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _______ (Initial)

Signature of Patient/or Guardian of said Minor __________________________________ Date ___________

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