INTEGRATIVE BODY HEALTH
NUTRITION • CHIROPRACTIC • REHABILITATION

New Patient Application

WELCOME TO OUR CLINIC!

Welcome and thank you for applying as a patient to our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled many people to achieve their optimal health when many other systems may have failed. Due to the unique nature of our clinic, we may not accept you as a patient until we are absolutely certain that we know the cause of your condition and are able to establish an optimal rehab program, specifically for you. Please understand that if we accept you as a new patient, your health will need to be YOUR top priority. (as well as ours) At this point, specific recommendations will be tailored for your individual needs.

Thank you again for applying as a patient in our clinic.

Patient Signature: _____

Date: _____

PATIENT APPLICATION

Full Name:_____ Nickname:_____ Age:_____ Gender: [ ] M [ ] F

Home Street Address:_____ Home Phone: (___)_____

City, State:_____ Zip:_____ Cell Phone: (___)_____

E-mail: _____@_____ Work Phone: (___)_____

Birth Date: ____/____/____ Social Security #: ____ - ____ - ____ Marital Status: S M D W

Height:___'___" Weight: ___lb Race/Ethnicity: [ ]African American [ ]Arabic [ ]Asian [ ]Caucasian [ ]Hispanic [ ]Native Am.

Primary Spoken Language: _____ How were you referred to this office?_____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: (___)_____ Cell Phone: (___)_____

Spouse's Employer: _____ Occupation: _____

PURPOSE OF VISIT

Reason for appointment and related health problems:	Date condition started:	Have you had this before?	Injury related?
1. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
2. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
3. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No

EXPERIENCE WITH STANDARD CHIROPRACTIC

Have you seen a Chiropractor before? [ ] Yes [ ] No (If Yes) Name of doctor: _____

Reason for visit(s): _____ When: _____

How did you respond? _____

Did your previous Chiropractor take before and after X-rays? [ ] Yes [ ] No

Did your previous Chiropractor tell you that poor posture can negatively affect your overall health? [ ] Yes [ ] No

Did your previous Chiropractor make 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: _____

OTHER PROVIDERS

Medical Doctors seen:

Name: _____ Date of last visit:____ Is this your primary care provider? [ ] Yes [ ] No

Name: _____ Date of last visit:____ Is this your primary care provider? [ ] Yes [ ] No

Name: _____ Date of last visit:____ Is this your primary care provider? [ ] Yes [ ] No

Previous surgeries (all types) and dates: _____

What other testing or treatments have you tried to date for **present condition** with location (facility) and dates of those test and treatments: _____

_____

Current over-the-counter medications: _____

Current prescription medications: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend/shift forward with progressive muscle weakening and stretching of your spinal cord). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or development of a "hump" at the base of your neck? [ ] Yes [ ] No

Signature of Patient/ or Guardian: X _____ **Date:** _____

SOCIAL HISTORY AND LIFESTYLE

Do You exercises? [ ] Yes [ ] No How often? 1X 2X 3X 4X 5X per week, other: _____

What activities? [ ] Running [ ] Jogging [ ] Weight training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming [ ] Other: _____

Do you consider yourself to be… ? [ ] Underweight [ ] Normal weight [ ] Overweight [ ] Obese [ ] Severely obese

Do you smoke? [ ] Yes [ ] No How much? _____ Per [ ] day [ ] week [ ] month [ ] year

Do you drink coffee? [ ] Yes [ ] No How many cups per day? _____

What supplements do you take (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

Abnormal posture habits or distortions are the result of trauma or stress to the body that have misaligned regions of vertebrae in your spine. When these vertebrae are twisted from their normal position, they can cause physical stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations. It has been extensively documented that subluxations, causing physical stress to your nerves, can weaken and distort the overall structure of your spine. This is visualized as weakened and distorted POSTURE. Postural distortion can have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome or Posture (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 distortion from subluxations in your neck (such as Forward Head Syndrome) will affect the nerves into your neck, arms, hands and head, negatively influencing these parts of your body. Do you NOW or have you EVER experienced… ?

[ ] Neck Pain	[ ] Headaches	[ ] Pain into shoulders/arms/hands	[ ] Immune system weakness
[ ] TMJ/pain/clicking	[ ] Dizziness/fainting	[ ] Weakness in grip	[ ] Arthritis in the neck
[ ] Allergies/hay fever	[ ] Sinusitis	[ ] Visual disturbances	[ ] Hearing disturbances
[ ] Low energy/fatigue	[ ] Recurrent colds/flu	[ ] Thyroid conditions	[ ] Anxiety
[ ] Coldness in hands	[ ] Lack of focus	[ ] Numbness/tingling in arms/hands	[ ] Depression

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxation in the upper back (such as Forward Head Syndrome) will affect the nerves to the heart and lungs, negatively influencing these parts of your body. Do you NOW or have you EVER experience… ?

[ ] Upper back pain	[ ] Shoulder pain	[ ] Heart attacks/angina	[ ] Pain on deep inspiration/expiration
[ ] Shortness of Breath	[ ] Asthma/wheezing	[ ] Heart palpitations	[ ] High blood pressure
[ ] Tachycardia	[ ] Heart mumurs	[ ] High cholesterol	[ ] Recurrent lung infections/bronchitis

THORACIC SPINE (MID BACK):

Postural distortions from subluxation in the mid back will affect the nerves into your ribs/chest and upper digestive tract, negatively influencing these parts of your body. Do you NOW or have you EVER experience… ?

[ ] Mid back pain	[ ] Pain into ribs/chest	[ ] Scoliosis	[ ] Kidney disease	[ ] Diabetes
[ ] Ulcers/gastritis	[ ] Indigestion/heartburn	[ ] Hypoglycemia	[ ] Gall bladder problems	[ ] Nausea
[ ] Acid reflux	[ ] Liver disease	[ ] Tired/irritable after eating or when you haven't eaten for a while		

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxation in the low back will affect the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you NOW or have you EVER experience… ?

[ ] Low back pain	[ ] Pain into hips/legs/feet	[ ] Weakness/injuries in hips/knees/ankles
[ ] Numbness/tingling in legs/feet	[ ] Muscle cramps in legs/feet	[ ] Recurrent bladder/urinary tract infections
[ ] Coldness in your legs/feet	[ ] Frequent/difficulty urinating	[ ] Menstrual irregularities/cramping (females)
[ ] Constipation	[ ] Diarrhea	[ ] Sexual dysfunction

Please list any health conditions not mentioned:_____

Have you ever been diagnosed with cancer? [ ] Yes [ ] No If yes, explain:_____

HISTORY OF PRIMARY COMPLAINTS

Is this the first time you have had this pain? [ ] Yes [ ] No If No, when was the FIRST time you had these same symptoms?_____

How did the CURRENT episode of pain/discomfort occur? _____

How did the FIRST episode of pain/discomfort occur? _____

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain location: _____	Pain location: _____	Pain location: _____
RIGHT NOW: ____/10	RIGHT NOW: ____/10	RIGHT NOW: ____/10
At its WORST: ____/10	At its WORST: ____/10	At its WORST: ____/10
At its BEST: ____/10	At its BEST: ____/10	At its BEST: ____/10
AVERAGE: ____/10	AVERAGE: ____/10	AVERAGE: ____/10

What makes your pain DIMINISH? (check all that apply):

[ ] Nothing	[ ] Ice	[ ] Heat	[ ] Massage/rubbing	[ ] Exercise/activity	[ ] Sitting
[ ] Standing	[ ] Rest	[ ] Stretching	[ ] "Popping" the joints	[ ] Bracing/taping	[ ] Laying

[ ] Other: _____
[ ] Over-The-Counter Medications: _____
[ ] Prescription Medications: _____

What makes your pain WORSE? (check all that apply):

[ ] Coughing	[ ] Sneezing	[ ] Bearing Down	[ ] Sexual Intercourse	[ ] Running	[ ] Standing
[ ] Lifting	[ ] Bending	[ ] Pushing	[ ] Pulling	[ ] Driving	[ ] Sitting
[ ] Walking	[ ] Laying down	[ ] Movement of the head		[ ] Movement of the low back	

Other: _____

Bladder Function: If you have had any change in your bladder function, do you:

[ ] Urinate more often	[ ] Have loss of control or accidents	[ ] Have a sense of urgency
[ ] Have problems with sexual function	[ ] Have loss of sensation around the groin or buttocks	

Would you describe your pain as:

Location: _____	[ ] Constant	[ ] Frequent	[ ] Intermittent	[ ] Occasional	[ ] Seldom
Location: _____	[ ] Constant	[ ] Frequent	[ ] Intermittent	[ ] Occasional	[ ] Seldom
Location: _____	[ ] Constant	[ ] Frequent	[ ] Intermittent	[ ] Occasional	[ ] Seldom

Signature of Patient/or Guardian: X_____ Date: _____

Pain Quality:

How would you describe your pain/discomfort (check all that apply)

[ ] Dull	[ ] Aching	[ ] Stiff	[ ] Intense	[ ] Throbbing	[ ] Sharp	[ ]Crushing
[ ] Local	[ ] Stabbing	[ ] Shooting	[ ] Burning	[ ] Constricting	[ ] Radiating	[ ] Unbearable

Other: _____

Radiating: Does your pain seem to radiate from the primary area: [ ] Yes [ ] No If Yes, where does the pain radiate to? _____

_____

Numbness/Tingling (pins and needles): Do you experience or have you recently experienced numbness and/or tingling anywhere?

[ ] No [ ] Yes: Please describe where and when you feel these symptoms: _____

_____

Is your pain/discomfort WORSE:

[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day

Is your pain/discomfort BETTER:

[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day

FAMILY HEALTH HISTORY

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

[ ] Mental Health Disease	[ ] Neurological Problems	[ ] Lung Disease	[ ] Thyroid	[ ] Arthritis
[ ] Circulatory Problems	[ ] Immune System Problems	[ ] Heart Murmur	[ ] Back Pain	[ ] Cancer
[ ] High Blood Pressure	[ ] Heart Disease	[ ] Epilepsy	[ ] Stroke	[ ] Diabetes
[ ] Kidney Disease	[ ] Seizures	[ ] Migraine Headaches	[ ] Osteoporosis	[ ] Scoliosis
[ ] Liver Disease	[ ] Infectious Disease	[ ] Gall Bladder	[ ] Broken Bones/Fractures	
[ ] Autoimmune Disorders	[ ] Digestives Disorders	[ ] Other:_____		

Family History	Present Age(s)	Age(s) at Death	Medical Problems / Cause(s) of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

RADIOGRAPH CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Integrative Body Health, PC. , and/or his associates and assistants to take spine or other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with the clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Signature of Patient/or Guardian: X _____ Date: _____

ALL FEMALES: I also hereby declare to my knowledge that I am not pregnant _____

Initial

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use of spinal adjustments and rehabilitative exercises, traction and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The doctor and/or assistant will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or assistants specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorized the assignment of all insurance benefits be directed to Integrative body Health, its associated doctors and/or assistants for all services rendered.

_____ _____ x_____

Patient's Name Printed **Date** **Patient's Signature**

_____ _____

Guardian/Spouse's Signature Authorizing Care for Minor Date

IN CASE OF EMERGENCY

Name _____ Relationship _____

Work Phone (____)_____ Home Phone (____)_____ Cell Phone (_____) _____

INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? [ ] Yes [ ] No Policy # _____ Group # _____

Insurance Company Name: _____ Phone # _____

Address: _____

Insured's Name: _____ Birth Date: _____/_____/_____ Relationship: _____

For Automobile Accidents, what is the name of your Insurance Carrier? _____

Phone # _____ Policy Claim Number: _____

For work injury, what is your Employer Contact Name: _____ Phone # _____

Claim No. _____ if known, Insurance Carrier? _____

Other than yourself, who else should receive charges on your account? (CHECK ALL THAT APPLY)

[ ] Spouse [ ] Parent/Guardian [ ] Workers Comp [ ] Auto Insurance [ ] Medicare [ ] Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office **chooses** to bill any services to my insurance carrier this is done strictly as a **convenience** and **courtesy** for me. (We will only bill the insurance one time for a Date of Service at no charge to the patient.) This office may provide any necessary reports subject to reasonable service fees 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. Any monies received will be credited to my account. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services.

I also understand that I will be charged $25 for any and all scheduled appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian: X_____ **Date**:_____

HEALTHCARE AUTHORIZATION FORM (HIPPA)

THE FOLLOWING AUTHORIZES INTEGRATIVE BODY HEALTH, PC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Integrative Body Health, PC 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 alternative or other health related information as well as any advertisements, newsletters or patient of the week/month postings.
I give permission to Integrative Body Health, PC 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 assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.
By signing the following you are giving Integrative Body Health, PC permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: X_____ **Date:** _____

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.

Signature of Patient/or Guardian: X_____ **Date:** _____

FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care? [ ] YES [ ] NO

Referred out: _____

Doctor's Signature: _____Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of care, while offering considerable, benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustment may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care, and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name (printed)	Relationship to patient
Patient or legal Guardian Signature	Date
Witness Signature (office staff)	Date