Champaign Chiropractic Clinic
Chiropractic-Acupuncture-Rehab

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____
PATIENT NAME

_____
DATE COMPLETED

Patient Information

Name:_____ Nickname:_____ 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

Occupation: _____ Employer Name: _____

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

Spouse's Employer:_____ Occupation: _____# of Children: _____

How were you referred to this office? _____

** We will not publish, share or sell your email address in any way. By providing your email address, you give us the permission to send you emails regarding your care, appointments at our clinic, monthly newsletters and other correspondence from our office.*

Purpose for This Visit

Reason for this visit: _____

Is this related to an accident or specific injury* (other than auto or work-related)? □ Yes □ No If yes, when:___/___/____

Describe: _____

**If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.*

Please use the General Symptoms Chart on the next page to provide a detailed notation of your symptoms

When did these symptoms begin? ___/___/____ Are they: □ Constant □ Intermittent □ Activity-related

Are they getting worse □ Yes □ No Explain:_____

What activities aggravate your symptoms?_____ Is your pain worse: □ Morning □ Day □ Night

Do they interfere with: □ Work □ Sleep □ Hobbies □ Daily Routine □ Lifting □ Walking □ Sitting □ Standing □ Concentration

What have you done to relieve your symptoms? □ Heat □ Ice □ Rest □ Medication □ Other: _____

Have you experienced these symptoms before (if not accident/injury related)? □ Yes □ No

If yes, explain: _____

Have you been treated for this? □ Yes □ No When were you last treated? ___/___/____

Who did you see?_____ How did you respond?_____

What treatment was performed?_____

Are you allergic to rubbing alcohol? □ Yes □ No Work Days Missed: _____

Experience with Chiropractic

Have you seen a Chiropractor before? □ Yes □ No If yes, who?_____

Reason for visit(s): _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No What was the diagnosis? _____

Did they recommend a Home Health Care program? □ Yes □ No

If yes, what? _____ How long were you treated? _____ Last treatment: ___/___/____

How did you respond? _____

Are you aware of any poor posture habits? □ Yes □ No

Is there any history of spinal problems in your family? □ Yes □ No

If Yes, explain:_____

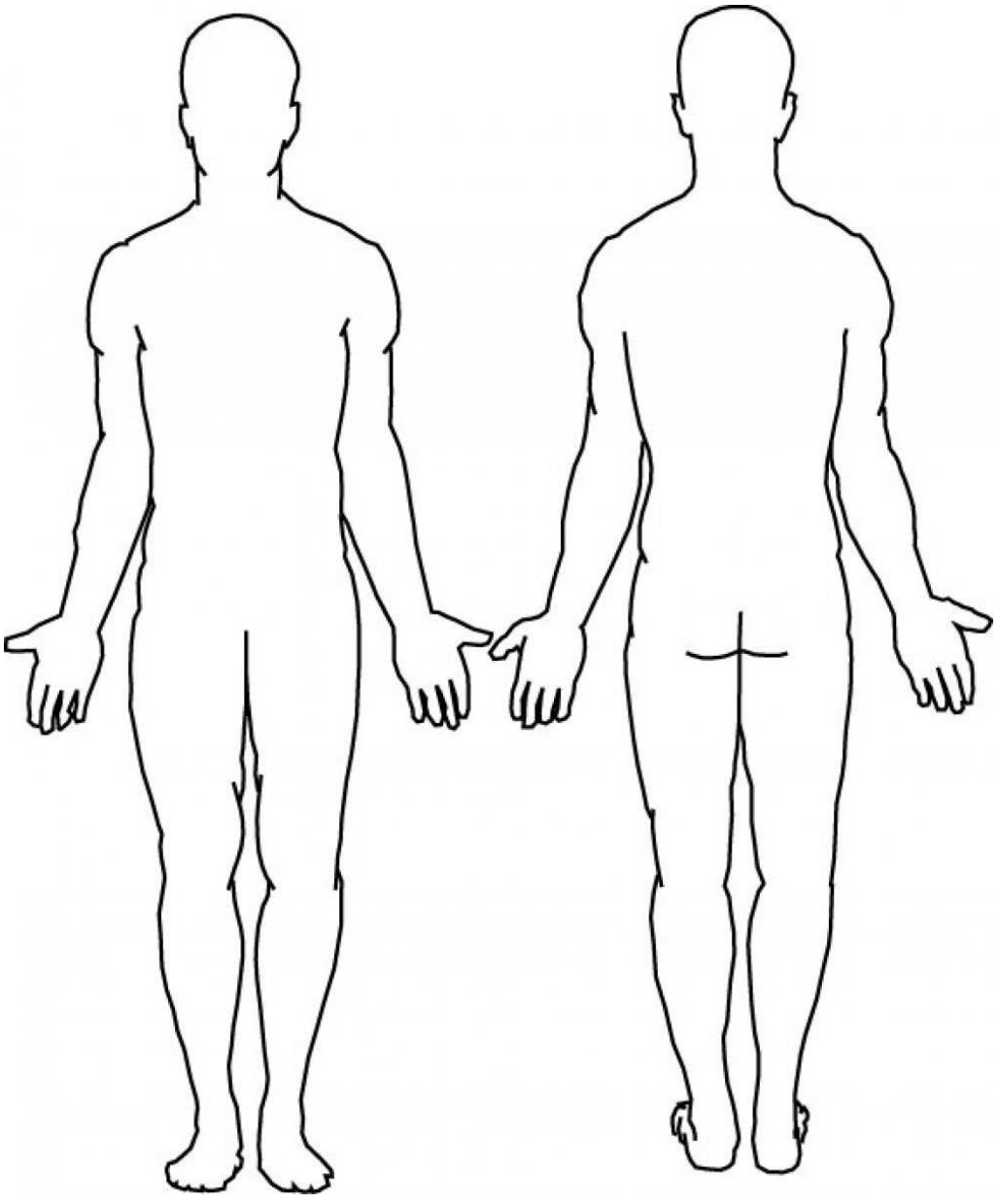
Have you ever had any car accidents, falls, or serious injuries? □ Yes □ No If yes, when:___/___/____

Describe: _____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	B = BURNING	D = DULL
N = NUMBNESS	P = PINS & NEEDLES	S = SHARP
M = SPASMS	G = STABBING	F = STIFFNESS
H = THROBBING	T = TINGLING	O = OTHER



FRONT BACK

Discomfort level: 0 1 2 3 4 5 6 7 8 9 10 (0=none 10=severe) Level you have experience with this _____ (0-10)

If you marked “O” for Other on any part, please explain below:

_____

_____

_____

Health & Lifestyle

Do you exercise? □ Yes □ No How often? ____day(s) per week; Other: _____

What activities? □ Walking □ Running/Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming

□ Other:_____

Do you drink alcohol? □ Yes □ No How much? / How often? _____

Do you drink coffee? □ Yes □ No How much? / How often? _____

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

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___Neck Pain	___Headache	___Sinusitis (Sinus infection)
___Pain in Shoulders/Arms/Hands	___Dizziness	___Allergies/Hay fever
___Numbness/Tingling in Arms/Hands	___Visual Disturbances	___Recurrent Colds/Flu
___Hearing Disturbances	___Coldness in Hands	___Low Energy/Fatigue
___Weakness in Grip	___ Thyroid Conditions	___TMJ (Jaw) Pain/Clicking

Please explain:_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___Heart Palpitations	___Recurrent Lung Infections/Bronchitis
___Heart Murmurs	___Asthma/Wheezing
___Tachycardia	___Shortness of Breath
___Heart Attacks/Angina	___Pain on Deep Inspiration/Expiration

Please explain:_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19:843-846.

Health Conditions *continued…*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in the mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___Mid Back Pain ___Nausea ___Diabetes

___Pain in Ribs/Chest ___Ulcers/Gastritis ___Reflux

___Indigestion/Heartburn ___Hypoglycemia/Hyperglycemia

___Tired/Irritable after eating or when not having eaten for a while

Please explain:_____

_____

_____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

___Pain in Hips/Legs/Feet ___Weakness/Injuries in Hips/Legs/Feet ___Low Back Pain

___Numbness/Tingling in Legs/Feet ___Recurrent Bladder Infections ___Coldness in Legs/Feet

___Frequent/Difficulty Urinating ___Muscle Cramps in Legs/Feet ___Sexual Dysfunction

___Constipation/Diarrhea ___Menstrual Irregularities/Cramping (females)

Please explain:_____

_____

_____

OTHER

Please list any health conditions not mentioned:_____

_____

_____

_____

Please list any surgeries (include type of surgery and date if it was performed):_____

_____

_____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the doctor at Champaign Chiropractic Clinic and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child and I will inform the treating doctor or staff about any chance of being pregnant verbally before the study is conducted. Date of last menstrual cycle: ___/___/____

Patient Signature:_____ Date: ___/___/____

Past Health History

Have you or any of your family members ever been diagnosed with the following (please indicate "Y" for You, and "O" for Other than you, or "B" for Both if applicable):

___Blood Pressure
___Cold Hands/Feet
___Difficulty Sleeping
___Eczema/Psoriasis
___Epilepsy/Seizures
___Headaches
___Heart Murmur
___Migraine Headaches
___Pneumonia/Bronchitis
___Rheumatic Fever
___Varicose Veins
___Visual Disturbances
___Appendectomy
___Tonsillectomy
___Metal Implants

___Cancer
___Diabetes
___Dizziness
___Ear Noises
___Fatigue
___Hernia
___Paralysis
___Pleurisy
___Stroke
___Influenza
___Measles
___Mumps
___Polio
___Small Pox
___Tuberculosis

___Whooping Cough
___Chicken Pox/Shingles
___Infectious Diseases
___Arthritis
___Broken Bones (fractures)
___Lumbago (low back pain)
___Osteoporosis
___Blood Sugar Problems
___Circulatory Problems
___Neurological Problems
Problems in:
___Bladder
___Colon
___Gall Bladder
___Heart

Problems in:
___Kidney
___Liver
___Lung
___Prostate
___Sinus
___Thyroid
___Neck
___Upper Back
___Mid Back
___Low Back
___Hip
___Arm
___Leg

___Other:_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and 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 his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient Name Printed _____

Patient Signature_____Date: ___/___/____

Parent/Guardian Name authorizing care of patient who is a minor _____

Parent/Guardian signature _____ Date: ___/___/____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded ___/___/____ County, State of Guardianship_____

I here by authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Name Printed _____

Guardian Signature_____ Date ___/___/____

In Case of Emergency

Name_____ Relationship_____

Cell Phone: ( ) _____ Work Phone: ( ) _____ Home Phone: ( ) _____

CONSENT FORMS

Privacy Notice Agreement

The Health Insurance Portability and Accountability Act (HIPAA) requires us to let you know how your Patient Health Information (PHI) is going to be used and your rights concerning those records.

I have been given a Notice of Privacy Practice which describes my rights concerning those records. I agree to allow this office to use my PHI for the purpose of treatment, payment, healthcare operations and coordination of care. I have the right to examine and obtain a copy of my health records and request corrections. I can request to know what disclosures have been made and submit any future restrictions. All staff will take precautions to assure my records are not available to those who do not need them and have a right to file a complaint with the office manager regarding any violations. I also understand there are some semi-private areas here where I may receive treatment. Staff at Champaign Chiropractic Clinic may call or write me with appointment reminders, cancellations and may leave voicemail messages at my home, mobile phone or place of employment.

Signature_____Date: ___/___/____

Financial and Insurance Agreement

As a courtesy to our patients, we will verify benefits, process your claims and do whatever we can to see that your carrier meets their obligation for payment. Your signature below authorizes us to release information necessary and assigns benefits to our office. In any cases where benefits are not assignable or where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to the clinic within 10 days of receipt unless you have paid for the services represented by said payment. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. In the unlikely event that your insurance carrier refuses to pay for treatment, you agree to be financially responsible for charges incurred. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

We accept checks, credit cards and cash. Payments may be made through the mail, phone or in person. We DO NOT accept cash payment in the mail. Any check returned to our office deemed Non-Sufficient Funds will be charges a **$35 fee**. A late charge of **12% per year** is applied to the account if the balance remains unpaid after **thirty (30) days** from when the bill is issued.

I hereby acknowledge that I have received the initial quote of benefit from the staff at Champaign Chiropractic Clinic. At this time, I have no further questions or concerns regarding my chiropractic benefit and understand that the verification of benefit is not a guarantee of payment.

I further understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carrier may deny my claims and that I am ultimately responsible for any portion of my treatment not covered by my insurance. This might include, but not limited to, deductible, co-pay, co-insurance, non-covered services, and etc.

Signature_____Date: ___/___/____

_____ Date: ___/___/____
Signature of Person Authorizing Care (if different from patient)

_____ Date of Birth: ___/___/____
Relationship to Insured