RESTORATION
FAMILY CHIROPRACTIC

New Practice Member Application

Who may we thank for referring you? _____

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Cell Phone_____ Work Phone _____ Occupation_____

Email Address_____ Employer's Name_____

Do you have HSA / Flex? Amt $: _____ Single / Married / Divorced / Widowed - Spouse's Name_____

Number of Children _____ Names, Ages, & Gender_____

FEMALES ONLY: Pregnant? Yes ___ No ___ How far along? _____ Due Date: _____ Gender: ___

List the health concerns that brought you into this office

Health Concern: List according to severity.	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
A: _____					
B: _____					
C: _____					
D: _____					

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

Please Mark "P" For In The Past *AND* Mark "C" For Currently Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other: _____

Please Mark "P" For In The Past OR "C" For Currently Have:

___Stroke ___Cancer ___ Heart attack ___ Spinal Surgery ____ Spinal Bone Fracture
___Scoliosis ___Diabetes ___ Arthritis ___ Seizures ____ Other Conditions

List all over the counter & prescription medications you are on and the reason (*attach sheet if necessary)*:

_____

Have you been in an auto accident? If so, when?:_____

Other trauma: _____

Quadruple Visual Analogue Scale

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 label if necessary.

EXAMPLE: No pain ____Neck_____ Back_____ Worst possible pain

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

1. How would you rate your pain RIGHT NOW?

_____
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

_____
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain ever get?)

_____
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

_____
0 1 2 3 4 5 6 7 8 9 10

Informed Consent For Chiropractic Care

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS 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) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THE CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL 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 FINDING WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

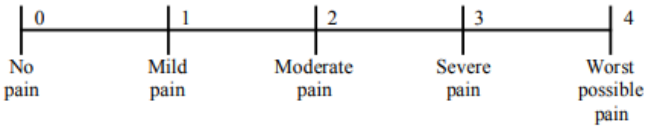
I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

Signature: _____ Date: _____

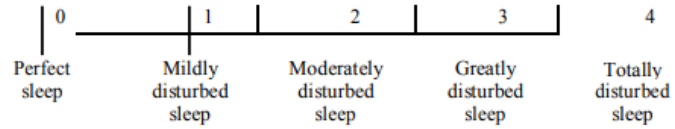
Functional Rating Index

Regarding your MAIN COMPLAINT. In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities. For each item below, please circle the one choice which most closely describes your condition right now.

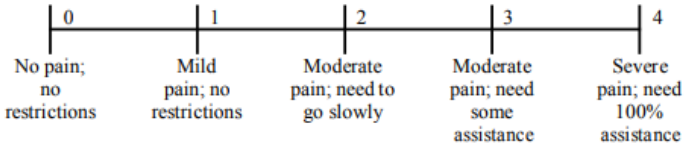
1. Pain Intensity



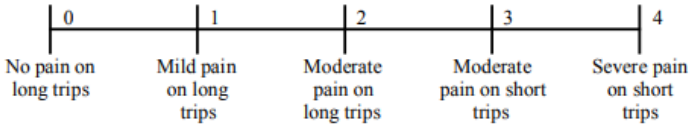
2. Sleeping



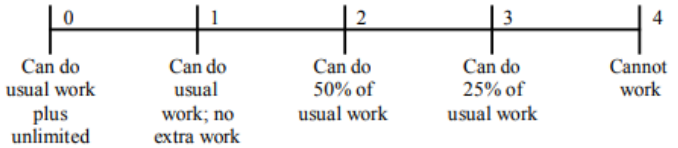
3. Personal Care (washing, dressing, etc.)



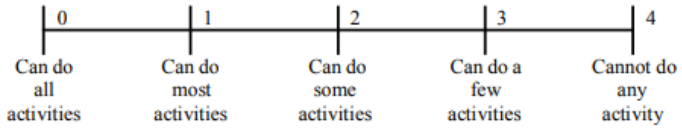
4. Travelling (driving, etc.)



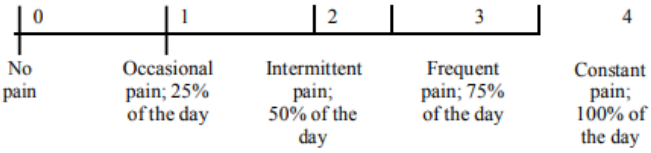
5. Work



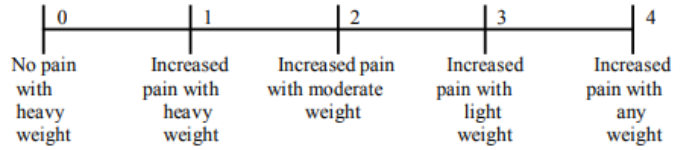
6. Recreation



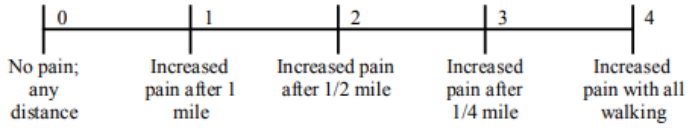
7. Frequency of Pain



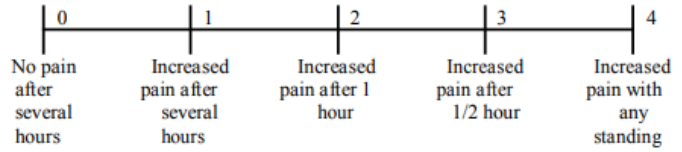
8. Lifting



9. Walking



10. Standing



HIPAA / Terms of Acceptance

THIS OFFICE CONFORMS TO THE CURRENT HIPAA GUIDELINES AND BEST PRACTICES. IF YOU WOULD LIKE A COPY OF THE HIPAA GUIDELINES, INFORMED CONSENT, OR TERMS OF ACCEPTANCE PLEASE SEE THE FRONT DESK. BY SIGNING BELOW YOU INDICATE THAT YOU HAVE BEEN MADE AWARE OF ITS AVAILABILITY:

Signature: _____ Date: _____

Medical Information Release Form (HIPAA Release Form)

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This will remain in effect until terminated by me in writing. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone

Signature: _____ Date: _____

X-Ray Authorization

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES. **THE FEE FOR COPYING YOUR X-RAYS IS $15.00**. THIS FEE MUST BE PAID IN ADVANCE. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.** THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF RESTORATION FAMILY CHIROPRACTIC DO 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.**

Signature: _____ Date: _____

FEMALES ONLY **Please check the box if it applies** ☐ 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.

Signature: _____ Date: _____

If this health profile is for a minor/child, please fill out and sign below:

Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Adam Smith and any or all Restoration Family Chiropractic staff to perform diagnostic procedures, spinal examinations, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Restoration Family Chiropractic.

Guardian Signature: _____ Date: _____

Relationship to minor/child: _____