APPLICATION FOR CARE AT STATERA CHIROPRACTIC

Whom may we thank for referring you to our office? _____

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 #: _____ 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: _____

PAST HISTORY

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 ***Past*** , **C** for ***Current*** or **N** for ***Never***

___ 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	**CONDITION**
INJURIES		
SURGERIES		
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)
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: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never

List Prescription & Non-Prescription drugs you take: _____

_____

REVIEW OF SYSTEMS- Please CIRCLE all Past or Current Symptoms

Headache	Numb/Tingling legs	Loss of Balance	Sexual Dysfunction	Ulcers
Neck Pain	Pregnant (Now)	Fainting	Digestive Problems	Heartburn
Jaw Pain/TMJ	Frequent Colds/Flu	Double Vision	Colon Trouble	Heart Problem
Shoulder Pain	Convulsions/Epilepsy	Blurred Vision	Diarrhea	High Blood Pressure
Upper Back Pain	Tremors	Ringing in Ears	Constipation	Low Blood Pressure
Mid Back Pain	Chest Pain	Hearing Loss	Menopausal Problems	Asthma
Low Back Pain	Pain w/Cough/Sneeze	Depression	Menstrual Problem	Difficulty Breathing
Hip Pain	Foot or Knee Problems	Irritable	PMS	Lung Problems
Sciatica	Sinus Problems	Mood Changes	Bed Wetting	Kidney Trouble
Back Curvature	Swollen/Painful Joints	ADD/ADHD	Learning Disability	Gall Bladder Trouble
Scoliosis	Skin Problems	Allergies	Eating Disorder	Liver Trouble
Numb/Tingling arms	Dizziness	Prostate Problems	Trouble Sleeping	Hepatitis (A,B,C)

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

_____ _____ - _____ - _____

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

STATERA CHIROPRACTIC

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 minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at STATERA 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 Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and 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.

_____	_____	____/____/____
Patient Name (print)	Patient Signature	Date
_____	_____	____/____/____
Parent/Authorized Person Name (print)	Parent/Authorized Person Signature	Date
_____	_____	____/____/____
Witness Name (print)	Witness Signature	Date

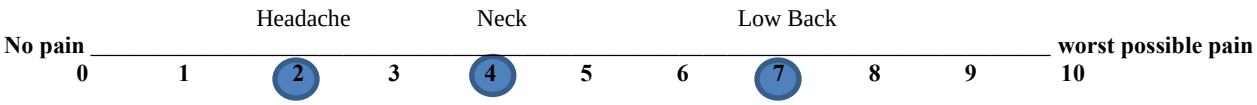
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



1 – What is 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 (How close to "0" does your pain get 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 (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

Examiner

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