



PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____

PATIENT APPLICATION SURVEY

Full Name _____ Today's Date _____
Date of Birth _____ Age _____ Gender F M Marital Status S M W D
Email _____ Social Security _____
Address _____ City _____ Zip _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer Name _____
Emergency Contact _____ Emergency Phone _____
Who Should We Thank for Referring You to Wellness Choice Center? _____

PURPOSE OF THIS VISIT

Health Issue	Date Condition Started	Frequency	Severity (0-10)
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____

Are these conditions getting worse? Yes No Is this: Constant Frequent Occasional Activity Related

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

- Dull Achy Throbbing Stiff Sharp Stabbing Shooting
 Intense Burning Constricting Other (please describe) _____

Does your condition interfere with:

- Work Sleep Hobbies Daily Routine (please describe) _____

What activities aggravate your symptoms?

- Coughing Sneezing Bearing Down Lifting Bending Pushing Pulling
 Driving Sitting Walking Running Standing Laying Down Movement

Is there anything, which has relieved your symptoms?

- Yes No
 Ice Heat Massage Resting Exercise Sitting Standing
 Bracing/Taping Stretching 'Popping' Joints Laying Other _____

PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? Yes No If yes, where? _____

Do you experience numbness and tingling anywhere? Yes No If yes, where? _____

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

Please Explain: _____

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

Please 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 felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1x 2x 3x 4x 5x per week Other: _____

What activities? Running/Walking Weight Training Cycling Yoga/Pilates Other: _____

Do you smoke? Yes No How much? _____

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

Do you drink coffee? Yes 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.

HEALTH LIFESTYLE (continued)

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:

- | | | | |
|---------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> TMJ/Pain/Clicking | <input type="checkbox"/> General Fatigue |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Hearing disturbances | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Low Metabolism |
| <input type="checkbox"/> Recurrent colds/flu | <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> Difficulty Losing Weight |
| <input type="checkbox"/> Pain into your shoulders /arms/hands | <input type="checkbox"/> Numbness/tingling in arms/hands | | |

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:

- | | | |
|---------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Asthma/ wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart attacks/angina |
| <input type="checkbox"/> Recurrent lung infections/bronchitis | | <input type="checkbox"/> Pain on deep inhalation / exhalation |

THORACIC 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:

- | | | |
|----------------------------------------------------|---------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion/heartburn |
| <input type="checkbox"/> Pain into your ribs/chest | <input type="checkbox"/> Ulcers/gastritis | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Tired/irritable after eating or when you haven't eaten | |

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:

- | | |
|--------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Pain into your hips/legs/feet | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infection |
| <input type="checkbox"/> Coldness in your legs/feet | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Muscle cramps in your legs/feet | <input type="checkbox"/> Menstrual irregularities/cramping (females) |
| <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Low back pain | |

Please list any health conditions not mentioned: _____

Please list any medication/surgeries: _____

MEDICAL HISTORY

Do you or any one in your family been diagnosed with any of the following:

- | | | | |
|-------------------------------------------------|-----------------------------------------------|------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmurs |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraine | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> AIDS |

Current Medications:

Over the counter medication (please list) _____

Prescription medication (please list) _____

Others/supplements (please list) _____

Please list any medication you are allergic to _____

Please list any allergies and reactions: (include dietary allergies) _____

Previous surgeries (all type) _____ Approximate date

1. _____

2. _____

3. _____

PRIMARY CARE PHYSICIAN INFORMATION

Doctor's Name _____ Specialty _____

Address _____ City _____ Zip _____

Telephone _____ Last Date of Visit _____

In order to provide complete and wholesome care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize Wellness Choice Center to contact your physician, request medical records, and/or co-manage your healthcare needs.

Patient's Name (Please Print) Date Patients Signature

Minor's Name (Please Print) Date Guardian's Signature

AUTHORIZATION & PRIVACY

AUTHORIZATION CARE

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical 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 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 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. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

Patient's Name (Please Print)

Date

Patients Signature

Minor's Name (Please Print)

Date

Guardian's Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES WELLNESS CHOICE CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Wellness Choice Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email massages 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 Wellness Choice Center 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 Wellness Choice Center 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 undersatand that I have the following right 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 operation.

Patient Name

Patient Signature

Date

Doctor's Name

Doctor's Signature

Date