Confidential Member Application - Health Review

Name: _____ Birth Date: ____-____-____ Age: _____ ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Phone: (Home) _____ (Cell) _____

Status: ☐S ☐M ☐W ☐D Employer: _____ Occupation: _____ Years on Job: _____

Spouse's Name:_____ Spouse's Employer: _____

Previous Chiropractic Care? ☐ Yes ☐ No When: _____ Where: _____

How did you hear about us: _____ **# Children and Ages:** _____

REVIEW OF SYMPTOMS

Please Mark **"C"** for Currently Have, **"P"** For In The Past or **"N"** For Never

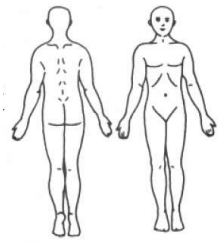
___ Headaches	___ Low back pain	___ Diabetes Type 1	___ Chest pain
___ Migraines	___ Tailbone pain	___ Diabetes Type 2	___ High blood pressure
___ Loss of balance	___ Shoulder pain	___ Increased thirst	___ High Cholesterol
___ Dizziness	___ Arm pain	___ Heat/Cold intolerance	___ Irregular heartbeat
___ Tremors	___ Elbow pain	___ Low blood sugar	___ Swelling of legs
___ Ringing in ears	___ Hand/wrist pain	___ Thyroid issues	___ Shortness of breath
___ Seizures	___ Hip pain	___ Tired/Sluggish	___ Excessive wt loss/gain
___ Slurred Speech	___ Leg pain	___ Change in skin color	___ Difficulty Sleeping
___ Stroke	___ Knee pain	___ Growth on skin	___ Sexual Dysfunction
___ General Weakness	___ Foot/ankle pain	___ Persistent itch	___ Ear Infections
___ Jaw/TMJ pain	___ Joint pain /Arthritis	___ Skin rash	___ Sinus Issues
___ Neck pain	___ Numb/Tingling arms, hands, fingers		___ Visual Changes
___ Mid-back pain	___ Numb/Tingling legs, feet, toes	___ Neuropathy	___ Memory loss

Other Conditions/Diseases: _____

LIST THE HEALTH PROBLEMS YOU ARE MOST INTERESTED IN GETTING CORRECTED:

List Health Concerns In order of severity	Rate Severity 0= No Issues 10=Unbearable	How long have you been suffering with this problem	Do you know what started this problem?	How many days per week do you notice this problem?
C1: _____	_____	_____	_____	_____
C2: _____	_____	_____	_____	_____
C3: _____	_____	_____	_____	_____

*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R=Radiating **B=B**urning **D=D**ull **A=A**ching **N=N**umbness **S=S**harp/**S**tabbing **T=T**ingling



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Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this in the past? ❑ No ❑ Yes When was the last episode? _____

Have your symptoms: ❑ Improved ❑ Worsened ❑ Stayed the same

List things you have tried: ◻ Gabapentin ◻ Neurotin ◻ Lyrica ◻ Cymbalta ◻ Pain Meds ◻ Ibuprofen ◻ Tylenol ◻ Motrin ◻ Aleve ◻ Injections ◻ Creams ◻ PT ◻ Massage ◻ Acupuncture **What were the results:** ◻ Favorable ◻ Unfavorable→ please explain. _____

Are you currently taking any medications[prescription or non-prescription]? ❑ No ❑ Yes

Please list: _____

Please identify any previous jobs that have created physical stress on your body: _____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer

___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

PLEASE identify ALL PAST & any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

How often?

1. **Smoking:** ❑cigars ❑ pipe ❑ cigarettes → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage:** consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom:❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister ❑ brother ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Drew-Montez Clark D.C. or Arc of Life Family Spinal Care, 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 Arc of Life Family Spinal Care for any and all services I receive at this office.

_____ ____ - ____ - ____

Patient or Authorized Person's Signature Date Completed

Confidential Member Application – Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

How Have Your Injuries Effected Each of The Below Activities? *On a Scale of 1-10, How Bad Is The Discomfort While Performing Each Action?* *0 = I can do it with no problem, 10 = I can't do it at all*							
Bending		Carrying		Climbing		Concentrating	
Dancing		Doing Chores		Computer Work		Dressing	
Driving		Gardening		Lifting		Sexual activity	
Sports		Pushing		Walking		Recreational activity	
Rolling Over		Running		Shoveling			
Standing Up		Sleeping		Static Standing			
Static Sitting		Working					

QUADRUPLE VISUAL ANALOG SCALE

C1 = Primary Complaint
C2 = Secondary Complaint
C3 = Tertiary Complaint

Write the answer to each question in the box that corresponds with the chief complaints.

Example — C1 (Neck Pain): 4; C2 (Headaches): 6; C3 (Leg Pain): 8

No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain **RIGHT NOW?**

C1 ☐ C2 ☐ C3 ☐ No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or **AVERAGE** pain?

C1 ☐ C2 ☐ C3 ☐ 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?)

C1 ☐ C2 ☐ C3 ☐ 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?)

C1 ☐ C2 ☐ C3 ☐ No Pain _____ Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

Examiner

Patient signature: _____ Today's Date: ___/___/____

Confidential Member Application – Quality of Life

1. What are your symptoms currently affecting and /or what are you worried they will affect in the future?

☐Sleep	☐Self Esteem	☐Work	☐Recreational Activities
☐Balance	☐Relationships	☐Finances	☐Time
☐Freedom	☐Kids/grandkids	☐Energy level	☐Future Abilities

2. How has your health condition affected the boxes marked above? Please give examples:

_____

_____

3. How have others been affected by your health condition?

☐No one is affected	☐They tell me to do something
☐Haven't noticed any problem	☐People avoid me as a result

4. If your symptoms are not treated, are there health conditions you are afraid this might turn into?

☐Heart Disease	☐Arthritis	☐Chronic Fatigue
☐Cancer	☐Fibromyalgia	☐Surgery or Amputation
☐Diabetes	☐Depression	☐Family Health Problems

5. What would be better/different in your daily life without these symptoms? Please be specific:

_____

_____

6. What are you most concerned with regarding your problem?

_____

_____

7. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

_____

_____

8. What do you desire most from working with us?

_____

_____

9. What would that mean to you?

_____

Confidential Member Application – Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started.

Please select any that apply to you:

Sub-Clinical symptoms including:
Headaches or Migraines

Hormone Imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating, cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma Allergies

Joint Conditions including:
Knee, Shoulder or Spine

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Thyroid Conditions including:
Hashimotos
Hypothyroidism
Hyperthyroidism

Developmental and Social Concerns including:
Autism
ADD/ADHD

Skin Conditions including:
Eczema
Skin rashes
Hives

Please select the correct number:

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, Hayfever or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Issues	0	1	2	3

YOUR TOTAL: _____

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to help you make an informed decision regarding your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.
Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
Vertebral subluxation is a disturbance to the nerve system and a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nerve system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation. It may also reduce pain, increase mobility and improve quality of life.
Physiotherapy or rehabilitative procedures may also be included in the management protocol.

Chiropractic care, like all forms of health care, may also provide some level of risk even though the risks are seldom high enough to contraindicate care. The types of complications that have been reported secondary to chiropractic care include: soreness, musculoskeletal sprain/strain, and rarely fracture. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

Prior to receiving care an examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and/or laboratory testing. These procedures will be performed to assess your specific condition, spinal health and overall well being. These procedures also assist us in determining recommendations, including referral to co-manage with another health care provider if necessary. All relevant findings will be reported to you along with a care plan prior to beginning care.

I have been informed of the nature and purpose of care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective.. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and give consent to the examination and resulting care recommendations.

_____ ____/____/____ *Witness Initials* _____
Patient or Authorized person's Signature Date

REGARDING: Non-Pregnancy Verification

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

□ The first day of my last menstrual cycle was on ___-___-___ Date

□ I hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic from any and all damages arising from any and all procedures of diagnostic X-rays or care nature with reference to the possibility of pregnancy.

_____ ____/____/____ *Witness Initials* _____

Patient or Authorized person's Signature Date

Notice of Privacy Practice Acknowledgment

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. I understand that this information cana and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
2. Obtain payment from third party payers
3. Conduct normal healthcare operations, suas as quality assessments and physician certifications.

In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party. I acknowledge that I may request your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment or healthcare operation.

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone except where required by law.

This Release of information will remain in effect until terminated by me in writing.

_____ ____/____/____ *Witness Initials* _____

Patient or Authorized person's Signature Date

Primary Care Physician

Please give the name, address and office phone number of your primary care physician.

Name: _____ Phone: _____ Address: _____

May we send them updates on your treatment/condition? ❑ No ❑ Yes

Written Consent for A Minor

Name of Practice Member who is a Minor / Child: _____

As of this date, I have the legal right to select and authorize healthcare services for the minor listed above. If my authority to select and authorize care is revoked or altered, I will immediately notice the office. By signing below, I give permission for the above named minor patient to be managed by the doctor, according to the agreed upon treatment program, even when I am not present to observe such care.

_____ ____/____/____ *Witness Initials* _____

Parent or Authorized person's Signature Date

INSURANCE VERIFICATION FORM

Member Name: _____ Date of Birth:____/____/_____

Social Security Number: _____ Marital Status: _____

Insurance Company(Primary): _____ (Secondary) _____

Name of Insured:*(if different)*_____ Date of Birth:____/____/_____

Insured Social Security Number:*(if different)* _____

Do you have a HSA / FSA? (Health/Flexible Savings Account) ☐ YES ☐ NO

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Drew-Montez Clark D.C. or Arc of Life Family Spinal Care. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED_____ DATE_____

For Office Use Only ☐ Calendar Year ☐ Physical Year Spoke with: _____

Ref #: _____ Effective Date of Ins: _____Date Verified: _____

Chiropractic Benefits: (Out-of-Network)

Deductible: _____ Amt Met: _____ Out of Pocket Max: _____ Amt Met:_____

Co-Pay: _____ Co-Ins: _____ Visits Covered: _____ Visits Used: _____

Notes(PT):_____

Referral: **YES / NO** Pre Authorization: **YES / NO** _____

Chiropractic Benefits: (In-Network)

Deductible: _____ Amt Met: _____ Out of Pocket Max: _____ Amt Met:_____

Co-Pay: _____ Co-Ins: _____ Visits Covered: _____ Visits Used: _____

Notes(PT):_____

Referral: **YES / NO** Pre Authorization: **YES / NO**