# Application for Care

Date: _____

**Patient Demographics**

Name: _____ DOB: _____/_____/_____ Age: _____ ☐ M ☐ F ☐Other

Street: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone # : _____ SSN _____

Marital Status: M S D W # of children: _____ Occupation: _____

**Insurance Information** Do you have insurance? ☐ Yes ☐ No

**Name of Primary Insurance**: _____ Subscribers Name: _____D.O.B_____

**Name of Secondary** : _____ Subscribers Name: _____D.O.B._____

**In Case of Emergency** Name & Phone Number:_____

Primary Care Physician: _____ Phone#_____

**History of Complaint**

Is the issue the result of a: ☐ Car Accident ☐ Work Injury Date of Injury: _____

When did it start? ☐ Days ago ☐ Weeks ago ☐ Months ago ☐ Years ago – Approx date /year_____

Rate your pain level at its **WORST**

*Major Complaint:* _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

*Other complaint:* _____ **No Pain 0- 1–2-3-4-5-6-7-8-9-10 Worst Pain**

How frequent is it occurring ? **circle one** Occasional – Intermittent- Frequent- Constant-

What makes your complaint better? ☐ adjustment ☐ topical analgesic ☐ exercise ☐ heat ☐ ibuprophen ☐ ice ☐ lying down ☐ medication ☐ no movement/rest ☐ sitting ☐ standing ☐ Stretching ☐Support ☐ yoga

What makes your complaint worse? ☐ bending ☐ coughing/sneezing ☐ driving ☐ lifting ☐ looking up ☐ looking down/ up ☐ laying faceup/facedown ☐ movement ☐ reaching ☐ rest ☐ sitting ☐sleeping ☐ standing ☐ stooping ☐ straining ☐ twisting ☐ walking

When is it occurring? ( select1 or more) ☐AM ☐ Midday ☐ PM ☐ At night ☐ >50% of day☐<50% of the day% of day ☐while sleeping ☐ while working

Have you been to a chiropractor before? ☐ No ☐ Yes Have you ever had x-rays? _____

Are you taking any medications? ____ Name and dose?_____

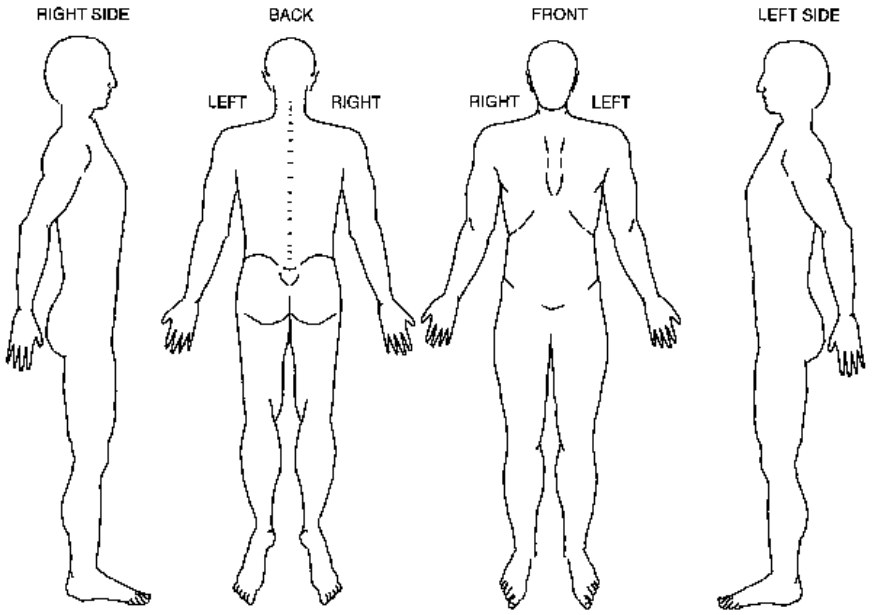
Other forms of treatment tried? ☐ No ☐ Yes If Yes, what type of treatment? _____

What were the results ☐ favorable? ☐ unfavorable?

**Put an X where ALL of your pain/ sensations are and label what it feels like**

Does the pain travel? _____ Where does it travel? Show where the pain travels below

A=Aching
B=-Burning
St=Stabbing
D=Dull
N=Numbness
P=Pins and needles
DP=Deep




Patient/ Parent or Guardian Signature: _____Date: _____

**PAST HISTORY**

**Select if you currently have or have <u>EVER</u> been diagnosed with any of the following conditions:**

_____arthritis/bursitis _____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis
_____diabetes _____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension
_____heart attack /disease / failure _____ kidney stones ____high cholesterol _____pacemaker
_____kidney issue _____leg swelling _____liver problems _____murmur _____ pneumonia _____reflux
_____ Rheumatoid arthritis _____sleep apnea _____ stroke _____thyroid issue_____ tuberculosis
_____whiplash _____Osteopenia/osteoporosis _____HIV _____Paget's disease
_____ Varicose Veins _____ tumors_____ ulcer_____ Muscular dystrophy _____multiple sclerosis
_____broken bones in the last 2 years _____ dislocations_____accidents (last 2 years)
_____ osteoarthritis _____ Allergies (_____) _____Surgery: Where?/When? _____

**SOCIAL HISTORY**

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarette ☐ E -cigarette/Vape
How much_____ How often? ☐ Daily ☐ Monthly ☐ yearly ☐ never
Alcoholic Beverages: How much _____ How often? ☐ Daily ☐ Monthly ☐ yearly ☐ Never
Recreational drugs :_____ How often? ☐ Daily ☐ Monthly ☐ yearly ☐ Never

**How well do you sleep?** ☐ Good ☐ Fair ☐ Poor Interruptions ? ☐ Yes ☐ No How many times/night?_____

**FAMILY HISTORY** Does anyone in your family suffer with these conditions? Check if applicable.

_____ angina _____arrhythmia _____bypass _____ cancer _____ cystic fibrosis _____diabetes_____ dialysis
_____ diverticulosis _____ emphysema _____ fibromyalgia _____gout _____hypertension _____murmur
_____heart attack/ disease/ failure _____hemophilia _____ kidney stone _____ Varicose Veins
____high cholesterol _____kidney issue _____liver issues _____ obesity _____pacemaker ____Rheumatoid arthritis
_____sleep apnea _____ stroke _____thyroid issue _____ tuberculosis _____Paget's disease _____ ulcer
_____ Muscular dystrophy _____multiple sclerosis_____ tumors
_____ Allergies: to what?->(_____) Other unlisted conditions: _____

**<u>ACTIVITY OF DAILY LIVING</u>** Explain how your condition is affecting your ability to perform activities

1. Carrying weight? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
2. Sitting to Standing ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
3. Climbing stairs? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
4. Computer/ Phone use? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
5. Reading? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
6. Getting dressed? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
7. Sexual activities? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
8. Sleep? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
9. Sitting? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
10. Yard work? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
11. Walking? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
12. Bathing/ Hygiene? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
13. House chores? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
14. Driving? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
15. Hobbies? ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform
16. Other? _____ ☐ No effect ☐ Painful (Can do) ☐ Painful (limits) ☐ Can't perform

Patient/ Parent or Guardian Signature: _____Date: _____

Quadruple Visual Analog Scale (QVAS)

Please rate the pain you are experiencing by circling the number for each question.

0 = No Pain, 10 = Worst Pain Possible

Pain site: (neck/back/ arm etc)_____

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Pain at its worst | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | Pain at its least: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | Pain on average: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. | Pain you feel right now | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Functional Limitation & Goal Statement – please complete the statement. Goals are unique to you and we want to address yours if you have any.

*My current condition is inhibiting my ability to* _____
*and I would like to improve my ability to* _____.
*My personal goal for care is to* _____.

These statements made on this form are accurate to the best of my recollection and I agree to allow **A. Nickel Chiropractic** to examine me for further evaluation. _____ **Initials**

Patient/ Parent or Guardian Signature: _____Date: _____

# Informed Consent

You are the decision-maker for your health care. Our role is to provide you with the information necessary to assist you in making informed decisions. This informed consent outlines your understanding and agreement regarding the care we recommend, the benefits and risks associated with that care, available alternatives, and the potential effects on your health if you choose not to receive care.

## Nature and Purpose of Chiropractic Care

Chiropractic care is based on the science of the relationship between the structure of the body—primarily the spine—and its function, particularly how it affects the nervous system. This relationship plays a vital role in the restoration and preservation of spinal health.

A chiropractic adjustment is a specific, high-velocity movement applied to the spine or extremity joints over a short distance. Its purpose is to correct subluxations—misalignments of the vertebrae—that may interfere with or irritate the nervous system. The primary goal of chiropractic health care is to remove this nerve interference.

A chiropractic examination may include spinal and physical assessments, orthopedic and basic neurological testing, specialized instrumentation, and possibly radiological imaging (e.g., x-rays). Occasionally, diagnostic procedures may be performed that are not strictly indicated but are conducted with care and professionalism. While exams and tests are performed carefully, some may be mildly uncomfortable.

There are various methods and techniques used to deliver chiropractic adjustments. While most adjustments are done by hand, some may involve instruments or specialized equipment. Additional supportive therapies or rehabilitation procedures may be included in your care plan, depending on your specific needs.

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## Benefits of Chiropractic Care

The potential benefits of chiropractic adjustments include:

- Restoring normal joint motion
- Reducing swelling and inflammation
- Decreasing joint pain
- Improving neurological function
- Enhancing overall well-being

Please note that, like all health care interventions, chiropractic results are not guaranteed, and no cure is promised.

**Treatment Modalities**- May be recommended based on your individual condition and response to treatment.

In addition to chiropractic adjustments, treatment may include supportive procedures such as:

- Ultrasound therapy
- Hot or cold packs
- Electrical stimulation
- Laser therapy
- Traction
- Rehabilitative exercises
- Other physical modalities

**Risks and Considerations-** PLEASE NOTE: All types of health care carry some risk.

Possible complications of chiropractic or physiotherapeutic treatment may include:

- Muscle spasms or soreness
- Joint or muscle pain
- Ligament sprains or strains

Patient/ Parent or Guardian Signature: _____Date: _____

- Dislocations
- Fractures (in rare cases, often due to underlying bone weakness)
- Neurological injury
- Vertebral Artery Syndrome (VAS), which may include stroke or, in extremely rare cases, death
- Burns or scarring from hot/cold therapies
- Allergic reactions

Some patients may feel soreness or stiffness in the first few days following treatment. While the risks are low and rarely contraindicate care, they should still be considered when deciding whether to proceed.

Probability of Risk Occurrence

Fractures are rare and usually stem from existing bone weakness, which we screen for during your history, physical exam, and imaging.

The relationship between cervical manipulation and vertebral artery dissection/stroke remains under investigation and debate. Current research is inconclusive about whether a causal link exists. If it does, such incidents are extremely rare. Unfortunately, there is no recognized screening procedure to definitively identify patients at risk for this complication.

Risks of Remaining Untreated

If left untreated, spinal and joint conditions may lead to the formation of adhesions and restricted mobility, potentially triggering a pain cycle that worsens over time. Delaying care can make future treatment more difficult and less effective.

Alternative Treatment Options- There are alternative treatments available.

-These may include:

- Self-care
- Over-the-counter or prescription medications
- Physical therapy
- Bracing or support devices
- Injections
- Surgery
- Doing nothing (watchful waiting)

-You also have the right to seek a second opinion regarding your condition and your care.

Consent for Evaluation and Treatment

By continuing with care, you are consenting to the following procedures as part of your chiropractic evaluation and treatment:

- Chiropractic adjustment and spinal manipulative therapy
- Light and deep palpation
- Vital sign assessment
- Range of motion testing
- Orthopedic and neurological testing
- Muscle strength testing
- Postural analysis
- Heat and cryotherapy
- Electrical muscle stimulation (EMS)
- Rehabilitative exercises

Patient/ Parent or Guardian Signature: _____Date: _____

**Patient acknowledgement**

- I have read the above consent and I understand the information provided.
- I have had an opportunity to ask questions about its content and all question.
- I have about this information have been answered to my satisfaction.
- I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplice-shed the desired objective.
- I have been told alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each.
- 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 treatment.
- I appreciate that it is not possible to consider every possible complication to care and by signing below
- I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance.
- I intend this consent to cover the entire course of care for my present condition and for any future conditions for which I seek chiropractic care from this office.

By signing below, I acknowledge receipt of this office's **Informed Consent**, provided on my behalf and in accordance with the law, and have read and understand the tactics regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you chose not to receive the care as a client of this practice. I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____

**Assignment of benefits/ Lien assignment/Release of information**

**Assignment of Benefits**

- I authorize payment to be made directly to, **A. Nickel Chiropractic**, for all benefits which may be payable under a healthcare plan or from any other collateral sources.
- I authorize use of this applications for processing claims and effecting payments.
- I acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **A. Nickel Chiropractic** for any/all serviced I receive at this office.
- I agree to pay for services at time services are rendered unless other financial arrangements have been made with **A. Nickel Chiropractic.**
- I agree to assign to **A. Nickel Chiropractic,** the benefits under my insurance policies for other reimbursement source.
- I recognize and accept responsibility for any balance remaining after payment of benefits. I acknowledge that any balance not covered or paid by such policy/ plan is my legal responsibility.
- I understand I am financially responsible for all charges whether paid by insurance or settlement.
- I agree to pay all charges unless credit arrangements are agreed upon in writing.
- I authorize **A. Nickel Chiropractic** to release all information necessary to secure the payments of benefits.
- I authorize the use of my signature on all my insurance submissions.
- I authorize benefits to be paid directly to the physician.
- I understand that I am responsible for any balance**.**

**PERSONAL INJURY ONLY –(SKIP IF NOT P.I.) Lien Assignment-** *If you're in need of treatment due to an accident, the office will work with your insurance and attorney to collect fees from responsible party's or the party's insurance company.*

- I, the injured party, agree to be responsible for all charges with **A. Nickel Chiropractic.** _____ **Initials**
- I agree to assign the designated portion of any settlement for judgement obtained in a lawsuit from the responsible party to **A. Nickel Chiropractic**. _____ **Initials**

**Release of Information**

- I authorize **A. Nickel Chiropractic** to release/obtain any information in my financial or medical records during my examination or treatment to/from my insurance company and its representatives and agents, health facilities with a written consent or any other person/entity affiliated with **A. Nickel Chiropractic** for the purposes of administration, billing, and collection. _____ **Initials**
- I authorize **A. Nickel Chiropractic** or my insurance company to release any information required to process my claim. _____ **Initials**
- I understand this consent applies to all records created during and related to my care with **A. Nickel Chiropractic**. _____ **Initials**

By signing below, I acknowledge receipt of this office's **Assignment of benefits/ Lien assignment/Release of information**, provided on my behalf and in accordance with the law, and I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____

**HIPAA Privacy Authorization Form.- Authorization for Use & Disclosure of Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act- 45 CFR Part 160-164)

- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be affected by my signing or not signing this release.
- I authorize **A. Nickel Chiropractic** to **use/ disclose** the protected health information described below for treatment and care.

  (Please Select Option A or B)

  A. I authorize the release of my complete health record.
  B. I DO NOT authorize the release of my complete health record.
  C. Do not discuss/release my medical records or private health information to anyone (including family members) or any entity.
    - This option is not available to patients under the age 18, although we must have written documentation indicating the adult with whom we will discuss care. _____ **Initials**
- I authorize **A. Nickel Chiropractic** to **release** all information to the following person.

  Name: _____ Relationship: _____
- This authorization shall be in force until revoked by me, (Pt name )_____.
- To revoke authorization, I will submit a Notice of Revocation in writing**.**
- I understand that I have the right to revoke this authorization at any time.
- I understand that a revocation is not effective in that any entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.
- **A. Nickel Chiropractic** and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below, I acknowledge receipt of this office's **HIPAA Privacy Authorization Form.- Authorization for Use & Disclosure of Protected Health Information**, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as a client of this practice. I was given the opportunity to read and ask questions.

Patient/ Parent or Guardian Signature: _____Date: _____