

Whom may we thank for referring you to this office? → _____

APPLICATION FOR CARE PORTSIDE SPINE & WELLNESS

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Marital Status: M S D W Name of Spouse or Significant Other: _____ # of Children: _____
Name & Number of Emergency Contact: _____ Relationship: _____
Health Insurance: ☐ Yes ☐ None Insurance Company: _____

HISTORY OF COMPLAINT - PLEASE IDENTIFY THE SYMPTOM(S) THAT BROUGHT YOU INTO THIS OFFICE

Primary Complaint: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your above complaints by circling the number:

Primary complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Secondary complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Third complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Fourth complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM

How long does it last? ☐ It is Constant ☐ It is Frequent ☐ It is Intermittent ☐ It is Occasional ☐ It is Infrequent

What relieves your symptoms? _____ What makes them feel worse? _____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes If yes, when? _____ By whom? _____

How long were you under care: _____ What were the results? ☐ Favorable ☐ Unfavorable _____

Name of Previous Chiropractor: _____ ☐ N/A

Is your problem the result of ANY type of accident? ☐ Yes ☐ No Date: ____ - ____ - ____

If yes identify type: ☐ Auto ☐ Work ☐ Home ☐ Other: _____

Have you reported this accident to anyone? ☐ No ☐ Yes If yes to whom: _____

When was your most recent auto accident? _____

Identify all sports or recreational activities you participate in:

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

Any other serious conditions the doctor should know about? _____

FAMILY AND PAST HISTORY

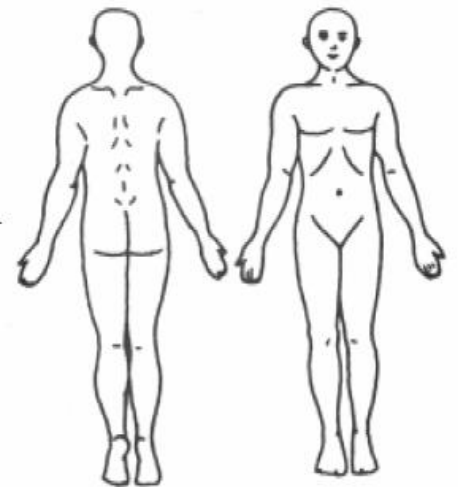
1. Any family history of disease or hereditary conditions? ☐ No ☐ Yes, Please Explain:

2. Any past surgeries: _____

3. Please list any current medications you are taking: _____

Please mark the areas on the diagram with the following letters to describe your symptoms:

R=Radiating B=Burning D=Dull A=Aching
N=Numbness S=Sharp T=Tingling



PLEASE MARK “P” FOR PAST, “C” FOR CURRENT, AND “N” FOR NEVER FOR EACH OF THE FOLLOWING:

☐ Headache	☐ Pregnant (Now)	☐ Dizziness	☐ Prostate Problems	☐ Ulcers
☐ Neck Pain	☐ Frequent Colds/Flu	☐ Loss Of Balance	☐ Impotence/Sexual Dysfunction	☐ Heartburn
☐ Jaw Pain/TMJ	☐ Convulsions/Epilepsy	☐ Fainting	☐ Digestive Problems	☐ Heart Problem
☐ Shoulder Pain	☐ Tremors	☐ Double Vision	☐ Colon Trouble	☐ High Blood Pressure
☐ Upper Back Pain	☐ Chest Pain	☐ Blurred Vision	☐ Diarrhea/Constipation	☐ Low Blood Pressure
☐ Mid Back Pain	☐ Pain with a Cough or Sneeze	☐ Ringing in the Ears	☐ Menopausal Problems	☐ Asthma
☐ Low Back Pain	☐ Foot or Knee Problems	☐ Hearing Loss	☐ Menstrual Problems	☐ Difficulty Breathing
☐ Hip Pain	☐ Sinus/Drainage Problem	☐ Depression	☐ PMS	☐ Lung Problem
☐ Back Curvature	☐ Swollen/Painful Joints	☐ Irritable	☐ Bed Wetting	☐ Kidney Trouble
☐ Scoliosis	☐ Skin Problems	☐ Mood Changes	☐ Learning Disability	☐ Gall Bladder Trouble
☐ Broken Bone	☐ Cerebral Vascular Problem	☐ ADD/ADHD	☐ Eating Disorder	☐ Liver Trouble
☐ Dislocation	☐ Diabetes	☐ Allergies	☐ Trouble Sleeping	☐ Hepatitis (A, B, C)
☐ Numbness/Tingling in Arms, Hands, or Fingers	☐ Disability	☐ Tumor	☐ Rheumatoid	
☐ Numbness/Tingling in Legs, Feet, or Toes	☐ Heart Attack	☐ Cancer	☐ Arthritis	

AFFECTS OF DAILY LIVING

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

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting out of Bed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Grooming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Physical Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Productivity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Toileting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

SOCIAL HISTORY

1. Smoking:

☐ cigars

☐ pipe

☐ cigarettes

How often?

☐ Daily

☐ Weekends

☐ Occasionally

☐ Never

2. Alcoholic Beverage(s):

☐ Daily

☐ Weekends

☐ Occasionally

☐ Never

3. Recreational Drug use:

☐ Daily

☐ Weekends

☐ Occasionally

☐ Never

FAMILY NUTRITION

1. Fast Food:

How often?

☐ Daily

☐ Weekends

☐ Occasionally

☐ Never

2. Dine Out:

☐ Daily

☐ Weekends

☐ Occasionally

☐ Never

3. Home Cooked:

☐ Daily

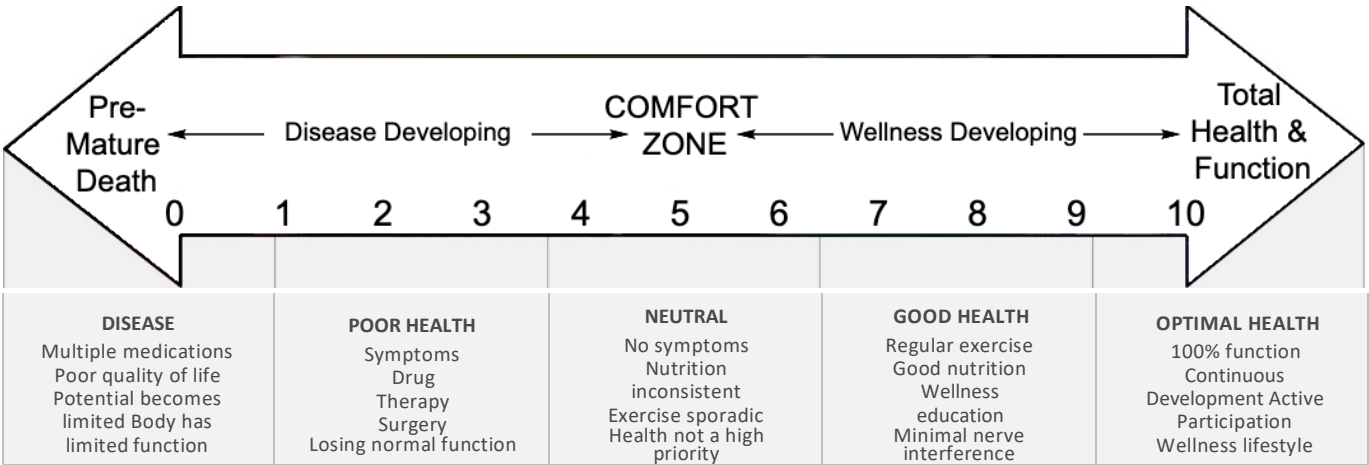
☐ Weekends

☐ Occasionally

☐ Never

What does a typical day's meals look like?

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

1. What number do you think represents your health today?

2. In what direction is your health currently headed?

What are your greatest stressors in life? (Work, Family, Ect...)

How committed are you to correcting this issue?

0

1

2

3

4

5

6

7

8

9

10

Not committed

Very committed

INFORMED CONSENT

REGARDING: Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

Treatment Objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Portside Spine & Wellness 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 a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

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.

I hereby authorize payment to be made directly to Portside Spine & Wellness, 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 Portside Spine & Wellness for any and all services I receive at this office.

Patient or Authorized Person's Signature

____/____/____
Date

Witness Initial

FEMALES ONLY: Please read carefully, and check the boxes, include the appropriate date, then sign above 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 have been provided a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. 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 statements below, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean open discussion, if you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes: To obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes: To process a claim or aid in investigation.
5. Emergency: In the event of a medical emergency we may notify a family member.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To government agencies or law enforcement: To identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. Change of ownership: In the event this practice is sold the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive detailed privacy notice.
3. To request mailings to an address different than residence.
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you, however you will be responsible for this cost.

I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this notice is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient Name

DOB

Patient Signature

Date

Witness

Date

PORTSIDE SPINE & WELLNESS OFFICE POLICY

Welcome to our Health Center!

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read Our Office Policies, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your **Application for Treatment**, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe first hand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ PATIENT PRIVACY – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Portside Spine & Wellness** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ FIRST THINGS FIRST- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wished to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objects of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices "Office Policies", the first page of which I have read and retained. This page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

Patient Name

DOB

Patient Signature

Date

Witness

Date