



# DEEP ROOTS CHIROPRACTIC

## NEW PRACTICE MEMBER APPLICATION

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Male/Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Cell \_\_\_\_\_ Home \_\_\_\_\_

Email: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship: \_\_\_\_\_ Who can we thank for referring you? \_\_\_\_\_

Status: Single / Married / Divorced / Widowed Spouse's Name \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Number of Children \_\_\_\_\_

Names, Ages, & Gender \_\_\_\_\_

### List The Health Concerns That Brought You Into This Office

Primary: \_\_\_\_\_ Is this problem constant or intermittent? \_\_\_\_\_

Second: \_\_\_\_\_ Is this problem constant or intermittent? \_\_\_\_\_

Third: \_\_\_\_\_ Is this problem constant or intermittent? \_\_\_\_\_

Fourth: \_\_\_\_\_ Is this problem constant or intermittent? \_\_\_\_\_

Have you ever seen other doctors for these conditions?  Yes  No

If Yes:  Chiropractor  Medical doctor  Other \_\_\_\_\_

Who? \_\_\_\_\_ When? \_\_\_\_\_ Results? \_\_\_\_\_

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Ear Infections       | <input type="checkbox"/> Sinus Issues     | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Sexual Dysfunction          |
| <input type="checkbox"/> Migraines       | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Frequent Colds   | <input type="checkbox"/> Bladder Problems     | <input type="checkbox"/> Sleep Problems              |
| <input type="checkbox"/> Jaw/TMJ Pain    | <input type="checkbox"/> Ringing in the Ears  | <input type="checkbox"/> Thyroid Issues   | <input type="checkbox"/> Menstrual Problems   | <input type="checkbox"/> Tight/Sore Muscles          |
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Sports Injury               |
| <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Loss of Energy       | <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Infertility          | <input type="checkbox"/> Sciatica                    |
| <input type="checkbox"/> Arm Pain        | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Arthritis/Joint Pain        |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux         |
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Tremors              | <input type="checkbox"/> Numb/Tingling in Arms/Hands |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Disc Problems        | <input type="checkbox"/> Numb/Tingling in Legs/Feet  |
| <input type="checkbox"/> Hip/Leg Pain    | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Stomach Problems            |
| <input type="checkbox"/> Knee Pain       | <input type="checkbox"/> Depression           | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Poor Posture         | <input type="checkbox"/> High/Low Blood Pressure     |
| <input type="checkbox"/> Foot Pain       | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Skin Problems        | <input type="checkbox"/> Difficulty Breathing        |
- Pregnant: Due Date?: \_\_\_\_\_  Stroke  Cancer  Heart Attack  Spinal Surgery
- Spinal Bone Fracture  Scoliosis  Diabetes  Arthritis  Seizures Other: \_\_\_\_\_

**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/Stabbing **T** = Tingling

What relieves your symptoms?

\_\_\_\_\_

What makes your symptoms feel worse?

\_\_\_\_\_

When is the problem(s) at its worst? → AM PM Mid-Day Late PM

\_\_\_\_\_

Please identify any & ALL types of jobs you have had in the past that have imposed any physical stress on your body:

\_\_\_\_\_

List all surgical operations & years:

\_\_\_\_\_

List any other injuries to your spine, minor or major, that the doctor should know about:

\_\_\_\_\_

List all over the counter & prescription medications you are on, & the reason for each:

\_\_\_\_\_

Have you ever been in an auto accident?

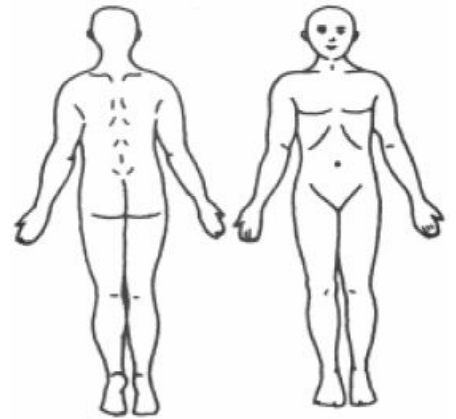
List all: \_\_\_\_\_

Have you ever been knocked unconscious?  Yes  No

Fractured A Bone?  Yes  No

If yes to either of the above, please describe: \_\_\_\_\_

Other trauma: \_\_\_\_\_



**SOCIAL HISTORY**

- 1. Smoking: How often?  Daily  Weekends  Occasionally  Never
- 2. Alcohol: How often?  Daily  Weekends  Occasionally  Never
- 3. Exercise: How often?  Daily  Weekends  Occasionally  Never
- 4. Recreational Drug Use: How often?  Daily  Weekends  Occasionally  Never
- 5. Have you consumed any caffeine or products with caffeine in the past 48 hours?  Yes  No

**QUADRUPLE VISUAL ANALOGUE SCALE**

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain \_\_\_\_\_ Back pain \_\_\_\_\_ Headaches \_\_\_\_\_ Worst possible pain \_\_\_\_\_  
 0 1 2 3 **4** 5 6 **7** 8 9 10

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

\_\_\_\_\_   
 0 1 2 3 4 5 6 7 8 9 10

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

\_\_\_\_\_   
 0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? \_\_\_\_\_%

**4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)**

\_\_\_\_\_   
 0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

**Office Use Only**

SCORE: #1 \_\_\_\_\_ + #2 \_\_\_\_\_ + #4 \_\_\_\_\_ = \_\_\_\_\_ / 3 x 10 = \_\_\_\_\_ (Low intensity = <50)(High intensity = >50)

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can 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 directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

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 used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

**Acknowledge & Initial Here:** \_\_\_\_\_

## INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke. Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to the doctors at Deep Roots Chiropractic. 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 practice member. 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. This pertains to any and ALL services rendered.

**Acknowledge & Initial Here:** \_\_\_\_\_

## DEEP ROOTS CHIROPRACTIC PHOTO RELEASE

I grant Deep Roots Chiropractic and its employees the right to take photographs of me with connections to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Deep Roots Chiropractic may use such photographs of me for any lawful purpose, including such purpose as publicity, illustration, advertising, and web content.

**Acknowledge & Initial Here:** \_\_\_\_\_

## X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Deep Roots Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FEMALES ONLY** ↓: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Deep Roots Chiropractic.

The first day of my last menstrual cycle was on \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Date)

**I have completed this form to the best of my ability. I understand that by completing this intake form, that I am supplying Deep Roots Chiropractic with all Personal Health Information that accurately relates to my current condition.**

\_\_\_\_\_  
New Patient or Authorized Guardian Signature

\_\_\_\_\_  
Date

### IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW WRITTEN CONSENT FOR A CHILD

Name of practice member who is a minor/child: \_\_\_\_\_

I authorize the doctors and any and all Deep Roots Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Deep Roots Chiropractic.

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship To Minor/Child: \_\_\_\_\_

↓ Doctor Use Only ↓

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature \_\_\_\_\_