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

# APPLICATION FOR CARE AT NEW JOURNEY CHIROPRACTIC

Today's Date: _____

## PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Date of Birth _____-_____-_____

Spouse's Employer_____ Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

## HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office, and on a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your complaints by ***circling the number*****:**

**Primary** or chief complaint is:_____ : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaint is:_____ : 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 primary problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

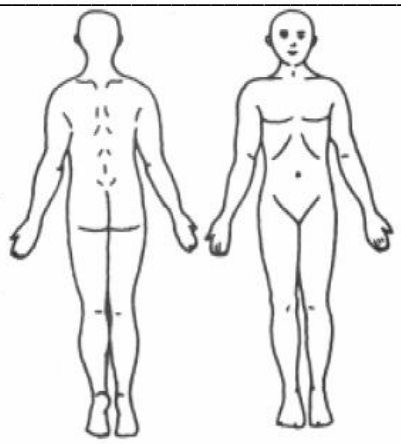
**How did the injury happen?_____**

**C**ondition(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? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

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



What relieves your symptoms? _____

What makes them feel worse? _____

| LIST RESTRICTED ACTIVITY: | CURRENT ACTIVITY LEVEL | USUAL ACTIVITY LEVEL |
|---|---|---|
| _____: | _____ | |
| _____: | _____ | |
| _____: | _____ | |

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No
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 or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or 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** and any **CURRENT** conditions you feel may be contributing to your present problem:

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|
| **INJURIES** → | | | |
| **SURGERIES** → | | | |
| **CHILDHOOD DISEASES** → | | | |
| **ADULT DISEASES** → | | | |

## SOCIAL HISTORY

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ 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, See pg 2- Activities of Life

## FAMILY HISTORY:

**1.** Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
**If yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ 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 New Journey Chiropractic 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 New Journey Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
**Patient or Authorized Person's Signature** **Date Completed**

_____ _____ - _____ - _____
**Doctor's Signature** **Date Form Reviewed**

# Activities of Daily Living/Symptoms/Medications

**Patient Name:** _____ **Date:** _____

## Daily Activities: Effects of Current conditions On Performance

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

| | | | | |
|---|---|---|---|---|
| Bending | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Concentrating | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing computer Work | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Gardening | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Playing Sports | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Recreation Activities | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Shoveling | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sleeping | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Watching TV | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Carrying | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dancing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Dressing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Lifting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Pushing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Rolling Over | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Working | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Climbing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Doing Chores | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Driving | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Performing Sexual Activity | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Reading | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Running | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Sitting to Standing | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |
| Walking | ☐ No Effect | ☐ Painful (can do) | ☐ Painful (Limits) | ☐ Unable to Perform |

**Please mark P** for in the **Past, C** for **Currently** have and **N** for **Never**

| | | | | |
|---|---|---|---|---|
| ___ Headache | ___ Pregnant (Now) | ___ Dizziness | ___ Prostate Problems | ___ Ulcers |
| ___ Neck Pain | ___ Frequent Colds/Flu | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ 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 w/Cough/Sneeze | ___ Ringing in Ears | ___ Menopausal Problems | ___ Asthma |
| ___ Low Back Pain | ___ Foot or Knee Problems | ___ Hearing Loss | ___ Menstrual Problem | ___ Difficulty Breathing |
| ___ Hip Pain | ___ Sinus/Drainage Problem | ___ Depression | ___ PMS | ___ Lung Problems |
| ___ Back Curvature | ___ Swollen/Painful Joints | ___ Irritable | ___ Bed Wetting | ___ Kidney Trouble |
| ___ Scoliosis | ___ Skin Problems | ___ Mood Changes | ___ Learning Disability | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers | | ___ ADD/ADHD | ___ Eating Disorder | ___ Liver Trouble |
| ___ Numb/Tingling legs, feet, toes | | ___ Allergies | ___ Trouble Sleeping | ___ Hepatitis (A,B,C) |

**List Prescription & Non-Prescription drugs you take**:_____

_____

_____

## INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports:
i.e. football, wrestling, basketball, baseball, soccer, tennis, golf, track and field _____

Trauma as a child: i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident_____

Work around the house – lifting, bending, woke up with stiff neck, "back went out" _____

**QUADRUPLE VISUAL ANALOGUE SCALE**

**Name:**_____ **Date:**_____

**Please read carefully:**

**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

## EXAMPLE:

| | | | | | Headache | | | | Neck Pain | | Low Back | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | **0** | **1** | **2** | **3** | **(4)** | **5** | **6** | **7** | **(8)** | **9** | **(10)** | **Worst Possible Pain** |

**1. What is your pain right now?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst Possible Pain** |

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst Possible Pain** |

**3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst Possible Pain** |

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

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **No Pain** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **Worst Possible Pain** |

**Other Comments:**

_____

_____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

# Informed Consent

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at New Journey Chiropractic 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 treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

**REGARDING:** X-rays/Imaging Studies

**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 have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

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.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

***New Journey Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY***

I have received a copy of New Journey Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices 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 an 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.

_____ ____/____/____  *Witness Initials*

Patient signature Date

***New Journey Chiropractic's NOTICE REGARDING OFFICE POLICIES***

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second 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.

_____ ____/____/____  *Witness Initials*

Patient signature Date

# PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

**Notice to Patient:**
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

**OPTIONAL Additional Items:**

**1)** May we confirm your appointments by email, text or phone? Yes No
**2)** May we leave a message on your answering device at home or cell phone? Yes No
**3)** May we discuss your condition with any members of your family? Yes No
If yes, provide names: _____
**4)** We utilize open adjusting bays. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to hold private conversations in a private room if requested.
Are you comfortable being treated in an open bay? Yes No

**Patient Acknowledgement:**
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____
Patient Printed Name

_____
Patient Signature or legal representative

_____
If legal representative, state relationship

_____
Date

**FOR OFFICE USE ONLY:**
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient, but it could not be obtained because:
___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency, it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

# New Journey Chiropractic Appointment Policy

**Consistency** The Doctor's recommendations for your appointment consistency is directly related to the diagnosed condition of your spine. Our goal is to NOT ONLY relieve your expressed concerns but ultimately eliminate any subluxations that stop the nerves from functioning properly. Our desire is to prevent any further conditions/diseases from developing in the future which may inhibit you to do what you love with those you love. When your X-RAYS reveal a corrected spine, we know we both have accomplished that objective. We will always support you in staying committed to your health by guiding you to stay on track with your appointments as you build momentum with each adjustment. Cancelling appointments is not an option. We ask you to reschedule any missed appointments immediately.

**Walk-In's** We are an Appointment Only practice. We are not able to accommodate Walk-In's. To make an appointment call 386-236-8085 or use The Scheduling App for available appointment times.

**Early or Late** We understand you may be early or late for your appointment. However, we must keep the other patients and doctor on time.

If you have arrived "EARLY" please be respectful of others and wait until your "actual" scheduled time.

*If you are "LATE" (10 min past your appointment) we will have to reschedule the adjustment for the next available time.

**No Call/No Show** We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't show up at all, you may be preventing another patient from getting much needed care. When the schedule looks "full" and we turn someone away, we could have indeed helped them if we had known your appointment was available. We require you to contact us 1 hour before your appt to avoid any fees and allow others to schedule in your time slot.

**1st No Call/No Show - Verbal warning 2nd No Call/ No Show -A $25 fee is charged to be paid before receiving your next adjustment and for every recurring No Call/No Show afterwards. Effective April 1, 2019.**

_____ _____ _____

**Print Name** **Signature** **Date**