

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? _____

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? _____

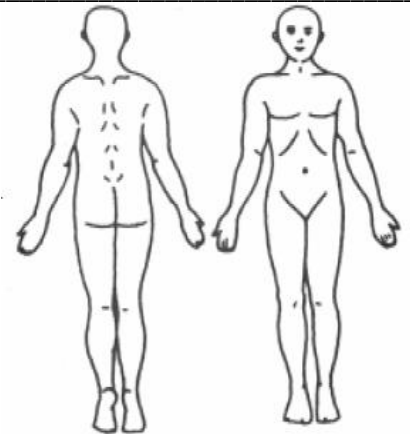
Name of Previous Chiropractor: _____ N/A

***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 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	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> 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:

OUR OFFICE POLICIES

Welcome to New Journey Chiropractic!

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 Care**, 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 interest 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 unique opportunity to observe firsthand 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.

- 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 New Journey Chiropractic is rendered primarily to minimize and reduce subluxations, which are major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal. 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 your 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 appointment, 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 wish 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 objectives 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.

New Journey Chiropractic's NOTICE REGARDING OFFICE POLICIES

I hereby acknowledge receipt of the practice's "Office Policies." I understand 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 or Authorized person's Signature

___/___/___
Date



Witness Initials

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

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