APPLICATION FOR CARE AT DYNAMIC LIFE CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

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

Name you wish to be called in our office: _____

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

E-mail Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

Employer: _____

Occupation: _____

Name of Spouse: _____ Spouse's Employer: _____

Occupation: _____

Names and Ages of your children: _____

Name & Number of Emergency Contact: _____ Relationship: _____

As a society we are 50th in the world in health care. We take pride in helping people to reach their optimum health and wellness. With that being said, we need an honest assessment of where you believe your current level of health is. So please place an "X" on the scale below marking where you believe your level of health and wellness is at this time. Then place a star (*) on the diagram indicating where you would like your health and wellness to be:

Very Challenged	Challenged	Transition	Good	Excellent
Premature Death		Absence of Disease		Optimal Wellness

HISTORY of COMPLAINT(s)

What brings you into our office? Below, please describe your primary and secondary problem. If you have no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the next page.

Primary Problem: _____

_____

_____

When did problem begin? _____

What relieves your symptom? Rest Ice Heat Movement Stretching Other _____

What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other _____

Frequency: Off & On / Constant Does the pain radiate? No / Yes Where? _____

How long does this problem last? _____ # of prior episodes? _____

Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore

On a scale of 0 to 10 with 10 being the worst and 0 being pain free, rate how you feel today (Circle the number): 0 1 2 3 4 5 6 7 8 9 10

Secondary Problem: _____

_____

_____

When did problem begin? _____

What relieves your symptom? Rest Ice Heat Movement Stretching Other _____

What makes your symptom worse? Sitting Standing Walking Sleeping Overuse Other _____

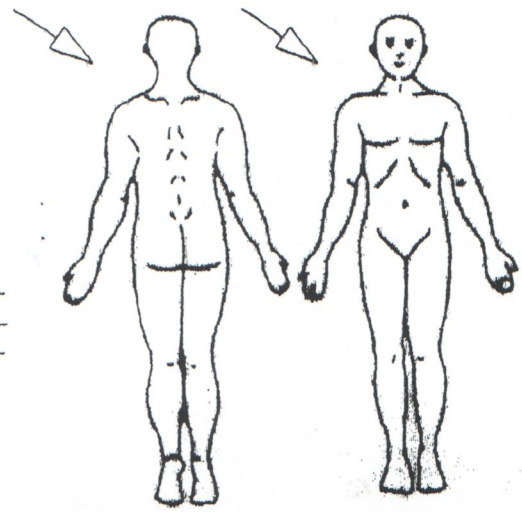
Frequency: Off & On / Constant Does the pain radiate? No / Yes Where? _____

How long does this problem last? _____ # of prior episodes? _____

Type of Pain: Sharp Stabbing Dull Achy Burning Stiff Sore

On a scale of 0 to 10 with 10 being the worst and 0 being pain free, rate how you feel today (Circle the number): 0 1 2 3 4 5 6 7 8 9 10

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



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these Problems ever been treated by anyone in the past? ☐No ☐Yes

If yes, Who provided: _____

How long ago? _____What type of treatment did you receive? _____

What were the results? ☐ Favorable ☐ Unfavorable → If unfavorable please explain:

_____

List any medications taken to treat these conditions: _____

Did they help? ☐ No ☐ Yes If you still take them how often? _____

Have you ever been under chiropractic care? ☐ No ☐ Yes If yes, how long ago: _____

Name of Previous Chiropractor: _____

Are any of your problem(s) today the result of ANY recent accident? ☐ No ☐ Yes

If yes,

How long ago? _____ Please explain what type of accident: _____

PAST HISTORY

1. 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:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ Other _____

2. PLEASE, identify ALL PAST and any unrelated current conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS			
ADULT DISEASES			
SURGERIES			
CHILDHOOD DISEASES			

Reserved for doctor's use only → Systems reviewed with patient:
❑ Musculoskeletal
❑ Neurological

For Women Only: Are you pregnant? (circle one) **Yes** **No**

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. How many years of school have you completed? ❑ 1-8 ❑ 8-12 ❑12-14 ❑14-16 ❑ 16 +

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)
2. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
3. **Any** other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

Whom may we thank for referring you into our office today? _____

How do you plan to take care of your charges today? ❑ Cash ❑ Check ❑ Credit Card

Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include, sprain/strain injuries, irritation of a disc condition, and - although rare- minor fractures. One of the rarest complications associated with Chiropractic cares (occurring at a rate between one instance per one million to one instance per two million) is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted by the doctor(s) in practice. This form was not signed until all my questions regarding treatment were answered to my complete satisfaction, and I conveyed my understanding of all risks to the doctor. After careful consideration, I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor discussed with me that he/she deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ Patient or Authorized Person's Signature

_____ - _____ - _____ Date Completed

Reviewed by: _____ Reviewer Initials

_____ Doctors Initials

NAME_____ DATE_____ ACCT.#_____

Rand 36-Item Health Survey 1.0

1. In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. **Compared to 1 year ago**, how would you rate your health in general now?

☐ Much better now than 1 year ago ☐ Somewhat better now than 1 year ago ☐ About the same
☐ Somewhat worse now than 1 year ago ☐ Much worse now than 1 year ago

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

CIRCLE ONE ON EACH LINE

	Yes, Limited a lot	Yes, limited a little	No, not limited at all
3. **Vigorous activities**, such as running, lifting heavy Objects, participating in strenuous sports	1	2	3
4. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
5. Lifting or carrying groceries	1	2	3
6. Climbing **several** flights of stairs	1	2	3
7. Climbing **one** flight of stairs	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking **more than a mile**	1	2	3
10. Walking **several blocks**	1	2	3
11. Walking **one block**	1	2	3
12. Bathing or dressing yourself	1	2	3

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

13. Cut down the **amount of time** you spend on work or other activities	Yes	No
14. **Accomplished less** than you would like	Yes	No
15. Were limited in the **kind** of work or other activities	Yes	No
16. Had **difficulty** performing the work or other activities (i.e. it took extra effort)	Yes	No

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

17. Cut down the **amount of time** you spend on work or other activities	Yes	No
18. **Accomplished less** than you would like	Yes	No
19. Didn't do work or other activities as **carefully** as usual	Yes	No

20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? **(Check One)**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

21. How much bodily pain have you had in the past 4 weeks? (Check One)

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

22. During the past 4 weeks, how much did pain interfere with your normal work (Including work outside the house and housework) (Check One)

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the 1 answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks...

CIRCLE ONE ON EACH LINE

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of th time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

How TRUE or FALSE is *each* of the following statements for you?

CIRCLE ONE ON EACH LINE

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a lot easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Patient Signature: _____ Date: _____

Dynamic Life Chiropractic

Notice of Privacy Practice

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 – our office policy, 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 of this page and return to out front desk receptionist.

Permitted Disclosures:

1. Treatment purposes –discussions with other health care providers involved in your care.
2. Inadvertent disclosures-open treating area 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 room.
3. For payment purposes- to obtain payment from any insurance co or other available collateral source-OR-
4. To obtain your recent address. In the event you move and do not leave a forwarding address, we may use your emergency contact information in whatever way necessary to locate and collect any outstanding sums you may owe to the practice/doctor.
5. For workers compensation purposes-to process a claim or aid in investigation
6. Emergency-in the event of a medical emergency we may notify a family member
7. 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
8. To government Agencies or Law Enforcement-to identify or locate a suspect, fugitive, material witness or missing person
9. For military, national security, prisoner, and government benefit purposes
10. Deceased persons-discussion with coroners and medical examiners in the event of a patient's death
11. Telephone calls or email and appointment reminders-we may call your home and leave a message regarding missed appointments or apprize you of changes in practice hours or upcoming events
12. Change of ownership-in the event this practice is sold the new owners would have access to your PHI.

Note: At any time, this office may update the list of your ways your PHI may be used and all updates are deemed retroactive

Your Rights:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To requests mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and to whom we release information
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

Complaints:

If you wish to make a formal complaint about how we handle your health information, please contact Dr. Kristin Gaines-Porlier at 636-887-3400. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Bldg Washington DC 20201

I understand that this office reserves the right to amend this notice of privacy at any time in the future and will make the new provisions effective for all information that it maintains past and present. My signature below is an acknowledgment that I have received a copy of Dynamic Life Chiropractic Patient Privacy Notice and I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient:_____ DOB:_____ ACCT #:_____

Patient Signature:_____ Date:_____

Witness: _____ Witness Signature:_____ Date:_____

Dynamic Life Chiropractic Office Policy

The best doctor/patient relationship is when there is complete understanding of the treatment and financial responsibilities between the doctor and the patient. Our primary concern is being able to schedule you as required without creating a problem for you in keeping your account up-to-date. This will allow you to obtain the health care you need and handle your fees in a convenient manner.

Insurance

We shall assist in all possible ways in helping you process and obtain all of the benefit for which you are eligible; but financial obligation is yours. For your own information, please check with your insurance company as to the policy benefits for which you are eligible. We will advise you to pay any amount due for the "deductable" or any other "non-covered" charges.

Medicare

Our office will submit all Medicare services to Medicare. Patients who have Medicare benefits are required to pay their portion as services are rendered. Once the annual deductible has been satisfied, the patient will be responsible for the portion not covered by Medicare.

Personal Payment

Patients who do not have Chiropractic included in their insurance coverage are expected to make payments at each visit. For your convenience, we accept: personal checks, MasterCard, Visa, and Discover. We will be happy to discuss your financial charges. This will allow you to obtain the healthcare you need and handle your fees in a convenient manner.

Payment Agreement

I have read and understand the Office Policy as it pertains to my financial responsibility. I understand that I am responsible for any balance due at the time that services are rendered. I am aware that if my account is past due by 30 days, there will be a 1.5% finance charge added to my balance monthly. Should collection of services be required, fees for those services will be added to my balance and will be my responsibility. I also understand that I am responsible for all court costs and attorney fees should legal action be required.

Consent

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatments, physical examinations, x-ray studies, chiropractic care, or any clinic services that he deems necessary in my case.

I agree that if I discontinue my care for any reason: 1) Any time of service or other house discounts will be voided. 2) I will pay the balance in full at the time.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

Is there a person or persons whom you wish to grant permission to access your medical record at our office?

Name:_____

Relationship:_____

Contact Information:_____

Name:_____

Relationship:_____

Contact Information:_____

If you choose **NOT** to grant permission to anyone please initial inside the box. ☐

Signature:_____

Printed Name:_____ Date:_____

If at any time you wish to revoke this permission, please notify the office immediately.