Patient Application Survey

Name_____ Age_____ M/F_____

Address _____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____

Email_____

Social Security #_____Driver's License #_____

Birth date_____ Marital Status_____ # of Children_____

Names of children_____Ages_____

Do you notice any poor postural habits in your children? Y N

Explain_____

How were you referred to this office? _____

Employer _____ Type of work _____

Work Address_____ Work Phone_____

Spouse's Name_____ Age_____

Employer_____ Work Phone_____

Type of Work_____ Cell Phone_____

Purpose of this Visit

Reason for this visit_____

Is this purpose related to an auto accident/work injury? Y N

Describe_____

What activities aggravate your symptoms? _____

Is there anything which has relieved your symptoms? Y N

Describe _____

Have you experienced this condition before? Y N

Who have you seen for this? _____ What did they do?_____

How did you respond?_____

Experience with Chiropractic

Have you seen a chiropractor before? Y N

Who?_____ When?_____

Reason for Visits_____

How did you respond?_____

Did you know your posture determines your health? Y N

Are you aware of any of your poor postural habits? Y N

Explain_____

Are you aware of any poor postural habits in your spouse or children?_____

Explain_____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening the whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or feel like you carry your head forward? Y N

Health Lifestyle

Do you exercise? Y N How often?_____

What activities? _____

Do you smoke? Y N How much?_____

Do you drink alcohol? Y N How much/week? _____

Do you drink coffee? Y N How many cups/day?_____

Do you take any supplements?(i.e. vitamins minerals, herbs)?_____

Health Conditions

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shun). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called **Forward Head Syndrome** (a "**hunched forward**" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health conditions you may be experiencing

CERVICAL SPINE (NECK):

Postural distortions from **subluxations**, (causing **Forward Head Syndrome**), in your neck will weaken the nerves into your arms, hands, and head and affect these parts of your body. Do you experience...?

- ☐ Neck Pain
- ☐ Pain into your shoulders
- ☐ Numbness/tingling in arms/hands
- ☐ Hearing disturbances
- ☐ Weakness in grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual disturbances
- ☐ Coldness in hands/feet
- ☐ Thyroid conditions
- ☐ Explain:_____ _____ _____
- ☐ Sinusitis
- ☐ Allergies/Hay fever
- ☐ Recurrent Colds/Flus

THORACIC SPINE (UPPER BACK):

Postural distortions from **subluxations**, (resulting from **Forward Head Syndrome**), in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- ☐ Heart Palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/Angina
- ☐ Recurrent lung infections/bronchitis
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

THORACIC SPINE (MID BACK):

Postural distortions from **subluxations**, (resulting from **Forward Head Syndrome**), in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia
- ☐ Tired/irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK):

Postural distortions from **subluxations** in the low back (resulting from **Forward Head Syndrome**), in the mid will weaken the nerves into you r legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- ☐ Low back pain
- ☐ Pain into your hips legs and feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in your legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Constipation/diarrhea
- ☐ Menstrual irregularities/cramping (females)
- ☐ Sexual dysfunction

Please list any health conditions not mentioned_____

Please list and medications/surgeries _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

CHIROPRACTOR NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Guardian/Parent/Representative)

(Provide name and relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

LIFESPRING CHIROPRACTIC INC.

PATIENT CONSENT FOR USE AND/OR DISCLOURE OF PROTECTD HEALTH INFORMATION CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

_____ (patient) hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its' health care operations. The Practice explained to me that the Privacy Notice is available to me at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand and consent to, the following paragraphs as noted in the Privacy Notice dated 04/14/03: Appointment Reminder; Directory/Sign-In Log; Birthday Cards/Newsletters; Special Events Days; Office Protocols; Referral Board; Change of Ownership; Family/Friends.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition an the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transaction, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that is I do not sign the Consent evidencing my consent to the used and disclosures described to me above and contained in the Privacy Notice, the the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative (e.g., Attorney in Fact, Guardian, Parent if a minor) Relationship

____/____/____ _____

Date Signed Witness