PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Date: _____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _____

Describe: _____

Please describe the pain & its location: _____

When did this condition begin? _____/_____/_____ When did you first notice it? _____

Is this condition getting worse? ☐ Yes ☐ No Is this condition: ☐ Constant ☐ Comes & goes ☐ Activity related

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:_____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

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

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Did you know posture determines your health? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

Date: _____

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee? Yes No 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-shuns). 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 condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

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

- ⑨ Neck Pain
- ⑨ Pain into your shoulders/arms/hands
- ⑨ Numbness/tingling in arms/hands
- ⑨ Hearing disturbances
- ⑨ Weakness in grip
- ⑨ Headaches
- ⑨ Dizziness
- ⑨ Visual disturbances
- ⑨ Coldness in hands
- ⑨ Thyroid conditions
- ⑨ Sinusitis
- ⑨ Allergies/Hay fever
- ⑨ Recurrent colds/Flue
- ⑨ Low Energy/Fatigue
- ⑨ TMJ/Pain/Clicking

Explain: _____

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…?

- ⑨ Heart Palpitations
- ⑨ Heart Murmurs
- ⑨ Tachycardia
- ⑨ Heart Attacks/Angina
- ⑨ Recurrent Lung Infections/Bronchitis
- ⑨ Asthma/Wheezing
- ⑨ Shortness Of Breath
- ⑨ Pain On Deep Inspiration/Expiration

THOPRACIC 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…?

- ⑨ Mid Back Pain
- ⑨ Pain Into Your Ribs/Chest
- ⑨ Indigestion/Heartburn
- ⑨ Reflux
- ⑨ Nausea
- ⑨ Ulcers/Gastritis
- ⑨ Hypoglycemia
- ⑨ 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) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ⑨ Pain into your hips/legs/feet
- ⑨ Numbness/tingling in your legs/feet
- ⑨ Coldness in your legs/feet
- ⑨ Muscle cramps in your legs/feet
- ⑨ Constipation / Diarrhea
- ⑨ Weakness/injuries in your hips/knees/ankles
- ⑨ Recurrent bladder infections
- ⑨ Frequent/difficulty urinating
- ⑨ Menstrual irregularities/cramping (females)
- ⑨ Sexual dysfunction
- ⑨ Low back pain

Please list any health conditions not mentioned: _____

Please list any medications / surgeries: _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

[] Diabetes	[] Varicose veins	[] Neurological problems	[] Lung Disease
[] Rheumatic fever	[] Circulatory problems	[] Stroke	[] Heart murmur
[] High blood pressure	[] Heart Disease	[] Cancer	[] Osteoporosis
[] Kidney disease	[] Epilepsy/seizures	[] Migraine Headaches	[] Arthritis
[] Liver disease	[] Metal Implants	[] Infectious disease	[] Gall bladder
[] Broken bones/fractures	[] Appendectomy	[] Tonsillectomy	[] Hernia
[] Pneumonia	[] Polio	[] Tuberculosis	[] Anemia
[] Whooping Cough	[] Chicken Pox	[] Mumps	[] Meals
[] Thyroid	[] Small Pox	[] Influenza	[] Pleurisy
[] Arthritis	[] epilepsy	[] Lumbago	[] Eczema

[] Other: _____

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or physical therapist for all services rendered.

_____	_____	_____	_____
Patient's Name Printed	Date	Patient's signature	Date

_____	_____	_____
Minors Name	Guardian/Spouse's Signature of Authorizing care for minor	Date

IN CASE OF EMERGENCY

Name_____

Relationship_____

Work Phone_____

Home Phone_____

Cell Phone_____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature_____ Date_____

Guardian or Spouse's Signature Authorizing Care_____ Date_____

I hereby authorize Gold Coast Chiropractic Center to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on your account?

❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Workers Comp ❑ Auto Insurance

❑ Medicare ❑ Personal Health Insurance

RADIOGRAPH CONSENT

I _____ do hereby give my consent to allow Gold Coast Chiropractic and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _____ (Initial)

Signature of Patient/or Guardian of said Minor _____ Date _____

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES GOLD COAST CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Gold Coast Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Gold Coast Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Gold Coast Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations