Advanced Spinal Rehabilitation Center

"The leading Northwest center for non-surgical treatment of scoliosis."

PATIENT APPLICATION FORM
MINOR

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

We only accept cases that we are confident we can help so 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!

Date: _____

Patient Name: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

PATIENT APPLICATION SURVEY—MINOR

Name: _____ Gender: M F Marital Status: S M D W

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____Father Cell Ph: ( ) _____Mother Cell Ph: ( ) _____

Minor Email Address: _____Birth Date: _____ / _____ / _____ (Age) _____

Social Security #: _____ - _____ - _____ # of Children in family: _____

Names of Children/Brother/Sister: _____ Ages: _____

Father Name: _____Occupation: _____Employer Name: _____

Father Work Phone: ( ) _____Father Email: _____

Mother Name: _____ Mother Occupation: _____ Employer Name: _____

Mother Work Phone: ( ) _____ Mother Email: _____

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 condition 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? ☐ 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 feel like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? ☐ Yes ☐ No

HEALTH CONDITIONS

Abnormal postures and 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…?

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

Doctor Only: _____

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

Doctor Only: _____

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	☐ Nausea	☐ Pain Into Your Ribs/Chest
☐ Ulcers/Gastritis/Colitis	☐ Indigestion/Heartburn	☐ Hypoglycemia
☐ Reflux	☐ Tired/Irritable after eating or when you haven't eaten for a while	

Doctor Only: _____

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…?

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

Please list any **accidents/falls** and dates: _____

Please list any **health conditions not mentioned**:_____

Please list any **medications / surgeries**: _____

Dominant side: R L or Ambidextrous (equally able to use both left and right appendages)

Female Menses: Has menstrual cycle started? ☐Yes ☐ No If yes, date started? _____

HEALTH HISTORY

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

[] Diabetes –Type:_____
[] Rheumatic fever
[] High/Low blood pressure
[] Kidney disease
[] Liver disease
[] Broken bones/fractures
[] Pneumonia
[] Whooping Cough
[] Thyroid
[] Arthritis
[] Chest Pains
[] High Cholesterol
[] Varicose veins
[] Circulatory problems
[] Heart Disease
[] Epilepsy/seizures
[] Metal Implants
[] Appendectomy
[] Polio
[] Chicken Pox
[] Small Pox
[] Epilepsy
[] Heart Surgery/Pacemaker
[] Scoliosis
[] Neurological problems
[] Stroke
[] Cancer
[] Migraine Headaches
[] Infectious disease
[] Tonsillectomy
[] Tuberculosis
[] Mumps/Measles
[] Influenza
[] Lumbago
[] HIV/Aids
[] Other: _____
[] Lung Disease
[] Heart murmur
[] Osteoporosis
[] Arthritis
[] Gall bladder
[] Hernia
[] Anemia
[] Hepatitis
[] Pleurisy
[] Eczema
[] Shingles

Are you taking any of the following:

[] Nerve Pills
[] Muscle Relaxer
[] Insulin
[] Pain Killers
[] Blood Thinner
[] Statin
[] Cannabis
[] Tranquilizer
[] Chemotherapy
[] Aspirin
[] Stimulant
[] Birth Control

Please list any allergies: _____

HEALTH LIFESTYLE

How much do you value your Health on a scale of 1-10? _____

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 other: _____

What time of day do you find yourself feeling tired or low energy? Morning Afternoon Evening I never feel tired

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? _____

How many days a week do you eat fast food or frozen food 1-3 4-6 7

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

On a scale of 1-10, how open are you to learning more about natural (preventative) solutions to your health needs? _____

How much daily stress do you experience? Mild Average Severe

HEALTH LIFESTYLE (CONT.)

Are you involved with sports/activities outside of school? (Ex. Soccer, horseback riding, trampoline, tennis) Yes No
If yes, please list_____

Do you play an instrument(s)? Yes No If yes, please list _____

Do you carry a backpack? Yes or No Approximately how heavy? _____

Do you use a cell phone? Yes No Do you text? Yes No

Please circle if you use the following: Desktop computer Laptop ipad

Number of hours/day using computer/laptop/ipad_____

Please circle if you carry: Purse Laptop Bag ipad

Where do you do your homework? On my bed At a desk At a Kitchen/dining table Other location: _____

IN CASE OF EMERGENCY CALL:

Name_____

Relationship to Minor: _____

Work Phone_____

Home Phone_____

Cell Phone_____

PREFERRED METHOD OF CONTACT

Circle all that apply and complete the information below: Phone Text Email

Home Phone_____

Cell Phone_____

Text: _____Preferred #: _____

Email:_____

****

I give permission to email statements as needed? Yes No

LIFE STRESSES EVALUATION

The following three areas of stress can cause the vertebrae to misalign (**subluxation**). Do you recognize any of these stresses? Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).

I. PHYSICAL STRESS:					Explain
Birth Trauma	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on a wallet for years	C	T	A	N	_____
Sleeping Position—Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for many hours	C	T	A	N	_____
Continuous hours sitting/standing	C	T	A	N	_____

II. EMOTIONAL STRESS:					Explain
Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Loss of a Loved One	C	T	A	N	_____
Shoveling, Painting, Gardening, Cleaning	C	T	A	N	_____

III. CHEMICAL STRESS					Explain
Smoker—Amount?	C	T	A	N	_____
Second-hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine —Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs	C	T	A	N	_____
(Example: Tylenol, Motrin)					

IV. Which do you feel are primary stresses? _____

_____

INSURANCE INFORMATION & POLICY

For Parent/Legal Guardian: 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. Staying informed at all times of my account status is my responsibility.** The Doctor's 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.

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

Patient/Legal Guardian Name _____ Date_____

Parent/Legal Guardian Signature Authorizing Care_____ Date_____

I hereby authorize Advanced Spinal Rehabilitation Center to administer care as deemed necessary to my child, a minor under the age of 18 years old.

You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy.

All patients under Maintenance Care will not be eligible for insurance assignment, unless otherwise stated. Charges for services rendered will be due at the time of service.

Name of Insurance Co. _____ Policy#_____

Address_____ Phone # _____

Insured's Name_____ Insured's SS# _____

For Automobile Accidents, include Policy Claim No._____

Relationship to Insured _____ Birthdate _____/_____/_____

Employer_____

Who should receive charges on this account?

☐ Patient ☐ Spouse ☐ Parent/Guardian ☐ Workers Comp ☐ Auto Insurance ☐ Medicare ☐ Personal Health Insurance

RADIOGRAPH CONSENT

I, (Parent/Legal Guardian Name) _____ do hereby give my consent to allow Advanced Spinal Rehabilitation Center and its representatives, as deemed by the examining physician to **take radiographs of (Minor Name)_____ spine and/or extremities.**

Female: I also hereby declare that to the best of my knowledge that **I am not pregnant** _____ (Initial) I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

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

FINANCIAL POLICY

We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH.**

Cell Phone Usage: HIPAA RULES: **No cell phones in treatment areas.** Please help us keep a peaceful, relaxing environment by putting your phone on silent mode or off. Please take your phone calls outside.

It is our Financial Policy that patients whose monthly payments are not paid on or before the 21st of each month, will incur a one-time service charge/late fee of $20.00 per late or missed monthly payment.

As a patient in our office, it will be your responsibility to keep scheduled appointments. If you need to cancel or reschedule an appointment we **require at least 24-hours notice**. If at least 24-hours notice is not received you will be charged a **$25.00 no-show fee**.

It is our policy that **ALL services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments,** regardless of whether or not this office accepts insurance assignment. It is also your patient responsibility to ask any and all questions regarding your account balance, payments and charges and to know at all times where your account stands.

Should you discontinue care for any reason other than being discharged by the doctor, all balances will become due immediately, payable in full.

All payments are expected at the time of service; including co-pays, co-insurance, deductibles, and/or time of service fees. Failure to pay any coupon or promotional special fees will result in being charged full retail fees.

Returned checks will be charged a $35.00 NSF fee per transaction. All balances for services rendered that are over 60 days will be charged 1% simple interest on that balance each month on the first of the month.

All accounts not paid within ninety (90) days will automatically be sent to an outside collection agency.

PARENT/LEGAL GUARDIAN RESPONSIBILITY:

I certify that I have read and understand all of the above information. I understand that I am personally **financially responsible** for all services rendered whether or not paid for by my insurance. I am also responsible for any **annual deductibles applicable, co-payments, or non-covered services as may be required by my insurance plan.** I also agree to and understand that any balance over 60 days will incur 1% simple interest on the first of each month until paid in full.

x _____ _____

Signature of Patient or Person acting on Patient's behalf Date

PARENT/LEGAL GUARDIAN AUHTORIZATION:

I authorize the **release** of any **medical or other information necessary to process (Minor Name) _____claims**. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of Patient or Person acting on Patient's behalf Date

HEALTHCARE AUTHORIZATION FORM

_____(Initial) I authorize and agree to allow the doctors to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

_____(Initial) The doctors 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.

_____(Initial) I also clearly understand that if I do not follow the doctors 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.

THE FOLLOWING AUTHORIZES ADVANCED SPINAL REHABILITATION CENTER TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

_____(Initial) I give permission to Advanced Spinal Rehabilitation Center to **treat (Minor Name) _____in an open room** where other patients are also being treated. I am aware that **other persons in the office may overhear some of his/her protective health care information** during the course of treatment. Should the patient or parent/legal guardian need to speak with a doctor in private, the doctor will provide a private room for these conversations.

We may contact you to give you information about workshops or services related to your treatment, case management, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may put your picture, written or video testimonial up in our office or on our website. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Advanced Spinal Rehabilitation Center 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

I further acknowledge that a copy of the current notice is **posted in the reception area** and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed:_____ Date:_____

Print Name: _____ Telephone:_____

If not signed by the patient, please indicate:

Relationship: ☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Name of Patient:_____