



# Advanced Spinal Rehabilitation Center

*“The leading Northwest center for non-surgical treatment of scoliosis.”*

## PATIENT APPLICATION FORM

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 when compared to other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems of care.

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.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# PATIENT APPLICATION SURVEY

Name: \_\_\_\_\_ Gender: M F Marital Status: S M D W  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Age) \_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_ # of Children \_\_\_\_\_  
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 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 Do 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 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...?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Neck Pain                           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Sinusitis           |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies/Hay fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands     | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flu |
| <input type="checkbox"/> Hearing disturbances                | <input type="checkbox"/> Coldness in hands   | <input type="checkbox"/> Low Energy/Fatigue  |
| <input type="checkbox"/> Weakness in grip                    | <input type="checkbox"/> Thyroid conditions  | <input type="checkbox"/> 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...?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart Palpitations   | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis | <input type="checkbox"/> Heart Murmurs       |
| <input type="checkbox"/> Asthma/Wheezing      | <input type="checkbox"/> Tachycardia                          | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> 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...?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Mid Back Pain            | <input type="checkbox"/> Nausea   | <input type="checkbox"/> Pain Into Your Ribs/Chest |
| <input type="checkbox"/> Ulcers/Gastritis/Colitis | <input type="checkbox"/> Indigestion/Heartburn  | <input type="checkbox"/> Hypoglycemia              |
| <input type="checkbox"/> Reflux                   | <input type="checkbox"/> 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...?

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

Doctor Only: \_\_\_\_\_

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications / surgeries / Motor Vehicle Accidents: \_\_\_\_\_

## HEALTH HISTORY

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

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

Are you taking any of the following:

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Nerve Pills    | <input type="checkbox"/> Pain Killers  | <input type="checkbox"/> Cannabis     | <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Muscle Relaxer | <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Tranquilizer | <input type="checkbox"/> Stimulant     |
| <input type="checkbox"/> Insulin        | <input type="checkbox"/> Statin        | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> 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

## IN CASE OF EMERGENCY CALL:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

## 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	_____
<i>(Example: Tylenol, Motrin)</i>					

IV. Which do you feel are primary stresses? \_\_\_\_\_

\_\_\_\_\_

## INSURANCE INFORMATION & POLICY

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 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.

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's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's 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 \_\_\_\_\_ do hereby give my consent to allow Advanced Spinal Rehabilitation Center and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

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 \_\_\_\_\_



# HEALTHCARE AUTHORIZATION FORM

\_\_\_\_\_ 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.

\_\_\_\_\_ 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.

\_\_\_\_\_ 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:

\_\_\_\_\_ I give permission to Advanced Spinal Rehabilitation Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday-related cards, health-related e-mail messages and information about treatment alternatives or other health related information, as well as any advertisements, newsletters, testimonials or patient-of-the-week/month postings.

\_\_\_\_\_ I give permission to Advanced Spinal Rehabilitation Center 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 in private, the doctor will provide a private room for these conversations.

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

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**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: \_\_\_\_\_