INVICTUS CHIROPRACTIC

TEAM MEMBERS ONLY

Today's Date: _____-_____-_____

PM File Number: _____

New Practice Member Application

PATIENT DEMOGRAPHICS

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

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

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced Do you have Insurance: ☐ Yes ☐ No Have you served in the military: ☐ Yes ☐ No

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children, ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

Whom may we thank for referring you to this office? _____

HISTORY OF CURRENT HEALTH CONCERNS

List the Health Concerns that brought you into this Office

	List Concerns According to Severity	Rate of Severity 0 = No Pain 10 = Unbearable	When did this problem start?	Have you had this problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary	_____	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____	_____
Fourth	_____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? □ Yes □ No Who? _____

If Yes: □ Chiropractor □ Medical doctor □ Other_____

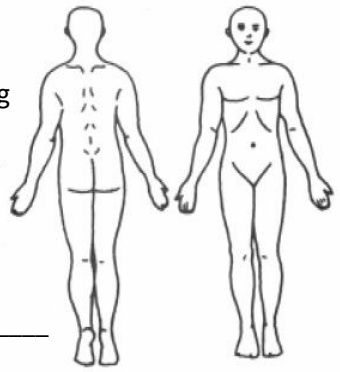
Name of Previous Chiropractor: _____ ☐ **N/A** Name of MD: _____ ☐ **N/A**

When?_____ Results?_____

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

What relieves your symptoms? _____ What makes your symptoms feel worse? _____

PLEASE MARK the areas on the Diagram with the following **LETTERS** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



List any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

List **PRESCRIPTION** & **NON-PRESCRIPTION DRUGS** you take, and provide a **REASON** for taking each one (i.e. Zantac – Allergies):

_____

_____

Please Mark "**P**" For in The **Past** OR Mark "**C**" For **Currently** Have:

__Acid Reflux	__Double/Blurry Vision	__Menstrual Issues	__Shortness of Breath	**PAIN**
__ADD/ADHD	__Ear Infections	__Migraines	__Sinus Issues	__Arm
__Allergies	__Epilepsy/Convulsions	__Muscle Spasms	__Skin Problems	__Chest
__Anxiety	__Fatigue	__Muscle Weakness	__Sleep Issues	__Foot
__Arthritis/Joint Pain	__Fibromyalgia	__Nausea	__Spinal Bone Fracture	__Hip/Leg
__Asthma	__Food Sensitivity	__Nervousness	__Spinal Surgery	__Jaw/TMJ
__Bed Wetting	__GERD/Gastric Reflux	__Numb/Tingling in Arms/Hands	__Sports Injury	__Knee
__Bladder Issues	__Headaches	__Numb/Tingling in Legs/Feet	__Stiffness	__Lower Back
__Cancer	__Hearing Loss	__Stroke	__Thyroid Issues	__Mid Back
__Chronic Colds	__Heart Attack	__Plantar Fasciitis	__Tight/Sore Muscles	__Neck
__Constipation	__Heart Issues	__Poor Circulation	__Tremors	__Shoulder
__Depression	__High/Low Blood Pressure	__Poor Posture	__Ulcers	__Stomach
__Diabetes	__Infertility	__Prostate Issues	__Weight Loss/Gain	__Upper Back
__Diarrhea	__Irritability	__Ringing in the Ears	__Vertigo	Other_____
__Difficulty Breathing	__Kidney Issues	__Sciatica		_____
__Digestive Issues	__Loss of Balance	__Scoliosis	Pacemaker: Y N	_____
__Disc Issues	__Loss of Energy	__Seizures		_____
__Dizziness	__Memory Loss	__Sexual Dysfunction	Pregnancy Due Date:_____	_____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) / PAIN ASSESSMENT

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

Back pain **Headaches**

0 1 2 (3) 4 5 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>best</u>? _____%

4. What is your pain level at its WORST?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its <u>worst</u>? _____%

PAST HISTORY

Have you ever been in an auto accident? ☐ Yes ☐ No List all:_____

_____

Please list any additional Injuries and/or Health Concerns, that have NOT been previously mentioned, in the chart below:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES/TRAUMA →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Exercise: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

4. Have you consumed any caffeine or products with caffeine in the past 48 hours? ☐ Yes ☐ No

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

LIST ANY OTHER RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

FAMILY HISTORY

This form is to assist Dr. Jordan & Team Invictus by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer’s					

X-RAY AUTHORIZATION

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Invictus Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____ _____ - _____ - _____

Practice Member Printed Name **Date of Birth**

_____ _____ - _____ - _____

Practice Member Signature **Date Completed**

FEMALES ONLY: *To the best of my knowledge,* ***I BELIEVE I AM NOT PREGNANT*** *at the time the x-rays are taken at Invictus Chiropractic.*

Practice Member Signature: _____ **Date**: _____ - _____ - _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____ - _____ - _____

Practice Member Signature **Date Completed**

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.

- I authorize and request payment of insurance benefits directly to Jordan Carroll, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_____

Practice Member Printed Name

_____ _____ - _____ - _____

Practice Member Signature **Date Completed**

CHILD/MINOR INFORMED CONSENT FOR CHIROPRACTIC CARE

If This Health Profile Is For A Child/Minor, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Jordan Carroll and any and all Invictus Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize health care services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Invictus Chiropractic.

Guardian Signature: _____ Date: _____ - _____ - _____

Relationship to Child/Minor: _____