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

APPLICATION FOR CARE EXODUS HEALTH CENTER

Dr. David Jockers/ Dr. Adriana Blaise

Today's Date:_____ HRN: _____

PATIENT DEMOGRAPHICS

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

Address:_____City:_____State:_____Zip: _____

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

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #:_____Driver's License #: _____

Employer:_____Occupation: _____

Spouse's Name_____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact:_____Relationship: _____

REASONS FOR SEEKING CARE:

Reason for appointment & Health related issues	Dated condition started or how long?	Have you had this before	Injury related?
_____	_____	YES/ NO	YES / NO
_____	_____	YES / NO	YES / NO
		YES / NO	YES /NO
		YES / NO	YES /NO

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above reasons by c***ircling the number*:**

Primary Reason : 0 --- 1 --- 2 --- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second Reason : 0 --- 1 --- 2 --- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third Reason : 0 --- 1 --- 2 --- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth Reason : 0 --- 1 --- 2 --- 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

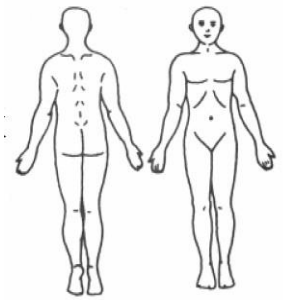
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when:_____by whom? _____

How long were you under care:_____ What were the results? _____

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



***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

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ No ☐ Yes **If yes** how many times?_____ When was the last episode?_____How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment:_____, and who provided it:_____**How long ago?**_____What were the results. ☐ Favorable ☐ Unfavorable☐ please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had***:**

___ Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability_____Cancer

___ Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular ___Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	**TYPE OF CARE RECEIVED**	**BY WHOM**
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___Pregnant (Now)	___Dizziness	___Prostate Problems	___Ulcers
___ Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Impotence/Sexual Dysfun.	_____Heartburn
___ Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___ Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___ Upper Back Pain	_____Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___ Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menopausal Problems	___Asthma
___ Low Back Pain	___Foot or Knee Problems	_____Hearing Loss	___Menstrual Problem	___Difficulty Breathing
___ Hip Pain	___Sinus/Drainage Problem	____Depression	___PMS	___Lung Problems
___ Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed Wetting	___Kidney Trouble
___ Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Eating Disorder	___Liver Trouble
___ Numb/Tingling legs, feet, toes		___Allergies	___Trouble Sleeping	___Hepatitis (A,B,C)

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes ☐ How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See Activities of Life

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister's ☐ brother's ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

2. Any other hereditary conditions the doctor should be aware of. ☐ No ☐Yes: _____

List Prescription & Non-Prescription drugs you take _____ _____
_____
_____

Activities of Daily Living

Daily Activities: Effects of Current conditions On Performance

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

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

What are your health goals?

How do you expect to achieve these goals?

EXODUS HEALTH CENTER

Dr. David Jockers/ Dr. Adriana Blaise

Informed Consent To Chiropractic Care

We encourage and support a **shared decision making process** between us regarding your health needs. As part of that process you have the right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

● **Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and how this relationship can affect the restoration and preservation of health.

● **Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurologica testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE THE DOCTORS OF EXODUS HEALTH CENTER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS _____ DAY OF _____, 20_____

_____ _____

Patient Signature **Doctor Signature**

Parental Consent for Minor Patient:
Patient Name:_____ Patient Age: _____ DOB: _____
Printed name of person legally authorized to sign for patient
Name: _____ Relationship to patient: _____

Signature: _____

REGARDING: X-rays/Imaging Studies

FEMALES ONLY ☐ *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on____---___---___Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____/_/ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

EXODUS HEALTH CENTER

Dr. David Jockers/ Dr. Adriana Blaise

HEALTHCARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy practices describes the types of uses and disclosures of my Protected Health information (PHI) that will occu in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of this notice is attached and I have been encouraged to read it and request a copy if I would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Chiropractic Family Wellness Centre to use and/or disclose my PHI in accordance with the following:

SPECIFIC AUTHORIZATIONS

- I give permission to use my address, phone number(s), email address, and clinical records to contact me with appointment reminders, missed appointment notification, billing/collection efforts, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other related information.

- I give permission to leave a phone message on my answering machine or voice mail.

- I give permission to send a thank you letter including my name to the person referring me to this office.

- I give permission to use my name on a welcome board, referral board, and birthday board.

- I give permission to use my photograph on their patient picture bulletin board and other marketing material such as their brochure, website and ads in print media.

- I give permission to use any testimonials written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, or on their website or in ads in print media.

- By signing this form you are giving Chiropractic Family Wellness Centre permission to use and disclose your PHI in accordance with the directives listed above.

The use of this format is intended to make my experience with this office more efficient and productive as well as embrace my access to quality health care and health information. This authorization will remain in effect for the duration of my care at Exodus Health Center plus 7 years or until revoked by me.

(OVER)

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revok this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on m authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Exodus Health Center. The written notice must contain the following information:

My name, Social Security number, address, and date of birth;
A clear statement of my intent to revoke this AUTHORIZATION
The date of you request; and
Your signature

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Exodus Health Center for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse this AUTHORIZATION, Exodus Health Center will not refuse to provide treatment, however, it will not be possible for Chiropractic Family Wellness Centre to file third party billing on my behalf (if applicable) and I will be responsible for **1) payment in full at the time services are provided to me 2) scheduling my own appointments since Exodus Health Center will be unable to contact me 3) all contact with Exodus Health Center regarding my care.** *Additionally, any collection activity as permitted by law is not waived by refusal to sign the AUTHORIZATION.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this patient Authorization to release Health Information and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient Name (printed): _____

Patient Signature: _____

Today's Date: _____ **SSN:** _____ **DOB:** _____

For minors or patients being represented by another party:

Parent or Personal Representative Name (printed): _____

Personal Representative Signature: _____

Today's Date: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

_____