NEW 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.

Date: _____

DEMOGRAPHICS

Name: _____ (Age) _____ Gender: M F

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Provider:_____

Email Address: _____

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 – Main Complaint:_____

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

When did this condition begin? ____/____/____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

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

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ___Arm __Leg ___Does not radiate

Is this condition getting worse? □ Yes □ No

What percentage of the day do you feel these symptoms? : 100% 75% 50% 25% 10% Only with Activity

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

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 x-rays? □ Yes □ No Did he/she take follow-up 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: _____

HEALTH LIFESTYLE

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

What type? Running Weight-Training Cycling Yoga Pilates Swimming Other:_____

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? _____

Please list all supplements, vitamins and herbs you take: _____

HEALTH CONDITIONS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:
_____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:
_____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:
_____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:
_____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Please list any health conditions not mentioned: _____

_____

Please list any medications currently taking and the purpose: _____

_____

Please list all past surgeries: _____

_____

Please list all previous accidents and falls: _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures. NOTE: It is understood and agreed the amount paid to Gardens Family Health Center for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Gardens Family Health Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor 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 treated 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 the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time, if not paid by then a 1.5% monthly interest will occur. In the event that it is necessary to retain an attorney, the prevailing party shall be entitled to recovery of attorney's fees and costs.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18) Parent's signature*

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____

_____ _____
Signature Date

Consent to x-ray:

I hereby grant Gardens Family Health Center permission to perform an x-ray evaluation if needed of _____. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

_____ _____
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child (if applicable)

I, _____ being the parent of legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

Acknowledgement of Behavior Policy for Patients

I, _____ do hereby acknowledge that as a patient or as a guardian of a patient who is a minor am responsible for being considerate of the needs of other patients and members of the staff. I understand that all minors must be accompanied by an adult at all times. I further understand that any disruptions caused by myself or any other person that I bring to the premises may be a cause for the staff to remove such persons from the premises.

_____ _____
Signature (parent if minor) Date

Procedure for Release of Medical Records

I,_____, understand that Gardens Family Health Center is governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patients' rights to confidentiality, as well as to track and report each request.

I, _____ hereby authorize Gardens Family Health Center, and its employees, agents, or assigns to release and disclose any and all medical records to me upon my request.

I, _____ understand that my request is valid for only 90 days. At the expiration of 90 days expires, a new written request form must be submitted.

_____ _____
Signature (parent if minor) Date

24 Hour Appointment Cancellation Policy

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of health care.

Gardens Family Health Center has a 24 hour cancellation / rescheduling policy.
We understand that sometimes you need to cancel or reschedule your appointments and there are emergencies.

This policy is in place out of respect for the Doctor, massage therapist and our clients. Please be courteous and kindly call the clinic at least 24 hours prior if you are unable to attend an appointment so that someone else urgently needing a treatment can be seen at that time. You may not cancel via email/ text.

There is no charge if your appointment is canceled 24 hours in advance. Appointments missed or canceled without 24-hour notification will be charged a Missed Appointment Fee of $25.

Our clinic in turn will do our best to minimize your waiting time. If your schedule is hectic or you are NOT sure if you can keep your appointment, then you can schedule it on the day of treatment (if availability permits).

_____ _____ _____

Printed Name Signature Date

_____ _____

Signature (parent if minor) Date