IDEAL SPINE
HEALTH CENTER

New Patient Application

Welcome to Our Clinic!

Welcome and thank you for applying as a patient to our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health even when many other systems may have failed. Due to the unique nature of our clinic, we may not accept you as a patient until we are certain that we know the cause of your condition and are able to establish an optimal rehab program specifically for you to help you recover your health. Please understand that if we accept you as a new patient, your health will need to be YOUR top priority as well as ours. At this point, specific recommendations will be tailored to your individual needs.

Thank you again for applying as a patient in our clinic.

Patient Signature: _____

Date: _____

NEW PATIENT APPLICATION

Full Name: _____ Nickname :_____ Age _____ Gender: [ ] M [ ] F

Home Street Address: _____ Home Phone: (____) _____

City, State, Zip:_____ Work Phone: (____) _____

Email Address: _____ Mobile Phone: (____) _____

Birth Date: _____ / _____ / _____ Social Security #: [redacted] Marital Status: S M D W

Height_____ Weight_____ Race/Ethnicity: [ ] African American [ ] Arabic [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native Am.

Do you consider yourself to be: [ ] Normal Weight [ ] Underweight [ ] Overweight [ ] Obese [ ] Extremely Obese

Primary Spoken Language: _____ How were you referred to this office? _____

Occupation:_____ Employer Name: _____

Spouse's Name: _____ Spouse Work Phone: (___) _____ Spouse Mobile: (___) _____

Spouse's Employer: _____ Occupation: _____

PURPOSE OF VISIT

Reasons for appointment:	Date condition started:	Have you had this before?	Injury related?
1. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
2. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
3. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No

EXPERIENCE WITH STANDARD 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 your previous chiropractor tell you that **poor posture** can negatively affect your overall health? [ ] Yes [ ] No

Did your previous chiropractor make 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:_____

OTHER PROVIDERS

Medical Doctors Seen:

Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No

Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No

Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Name:_____Date of last visit:_____ Is this your primary care provider? [ ] Yes [ ]No

Would you like us to forward our findings and recommendations to this physician? [ ] Yes [ ]No

Previous surgeries (all types) and dates: _____

_____

What other testing or treatments have you tried to date for **present condition** with location (facility) and dates of those tests and reatments:_____

_____

Current over-the-counter medications: _____

_____

Current prescription medications: _____

_____

_____

SOCIAL HISTORY AND LIFESTYLE

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_____

Do you consider yourself to be...? [ ] Underweight [ ] Normal weight [ ] Overweight [ ] Obese [ ] Severely obese

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much? _____ per [ ] day [ ]week [ ] Month [ ] Year

Do you drink coffee? [ ] Yes [ ] No How many cups per day? _____

What supplements do you take (i.e. vitamins, minerals, herbs)? _____

FAMILY HEALTH HISTORY

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

[ ] Mental Health Disease	[ ] Neurological Problems	[ ] Lung Disease	[ ] Thyroid	[ ] Arthritis
[ ] Circulatory Problems	[ ] Immune System Problems	[ ] Heart Murmur	[ ] Back Pain	[ ] Cancer
[ ] High Blood Pressure	[ ] Heart Disease	[ ] Epilepsy	[ ] Stroke	[ ] Diabetes
[ ] Kidney Disease	[ ] Epilepsy/Seizures	[ ] Migraine Headaches	[ ] Osteoporosis	[ ] Scoliosis
[ ] Liver Disease	[ ] Infectious Disease	[ ] Gall Bladder	[ ] Broken Bones/Fractures	
[ ] Autoimmune Disorders	[ ] Digestive Disorders	[ ] Other: _____		

Family History	**Present Age(s)**	**Age(s) at Death**	**Medical Problems / Cause(s) of Death**
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

☐ Please check here if you were adopted and this does not apply to you.

FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care? [ ] YES [ ] NO [ ] Referred out:

_____

*Doctor's Signature:*_____ *Date:* _____

IDEAL SPINE HEALTH CENTER

New Patient Application—Consent Forms

RADIOGRAPH CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Ideal Spine Health Center, PLLC and/or his associates and assistants to take spine or other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Signature of Patient/or Guardian:_____ **Date:** _____

ALL FEMALES: I also hereby declare to my knowledge that I am not pregnant _____.
Initial

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use of spinal adjustments and rehabilitative exercises, traction and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The doctor and/or assistant 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 and/or assistants specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

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

IN CASE OF EMERGENCY

Name_____Relationship_____

Work Phone (____)_____ Home Phone (____)_____ Cell Phone (____)_____

INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? [ ] Yes [ ] No Policy#_____ Group #_____
Insurance Co. Name _____ Phone #_____
Address_____
Insured's Name_____ Birth date: ____/____/____ Relationship_____
For Automobile Accidents, what is the name of your Insurance Carrier?_____
Phone # _____Policy Claim Number: _____
For Work Injury, what is your Employer Contact Name_____ Phone #_____
Claim No_____ If known, Insurance Carrier?_____

Other than yourself, who else should receive charges on your account? (CHECK ALL THAT APPLY)
[ ] Spouse [ ] Parent/Guardian [ ] Workers Comp [ ] Auto Insurance [ ] Medicare [ ] Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, 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 this is done strictly as a **convenience** and **courtesy** for me. (We will only bill the insurance one time for a Date of Service at no charge to the patient.) This office may provide any necessary reports subject to reasonable service fees 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. I authorize the assignment of all insurance benefits be directed to Ideal Spine Health Center, PLLC, its associated doctors and/or assistants for all services rendered. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services. I understand that in the case of worker's compensation, personal injury or other case where legal settlement is involved, if an insurance company issues a check for services received to either me, the patient, my legal guardian or to someone representing me such as an attorney, I am responsible for payment of bills in full within 14 days.

I also understand that I will be charged $25 for any and all scheduled appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian:_____ **Date:**_____

HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES IDEAL SPINE HEALTH CENTER, PLLC AND ASSOCIATES TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Ideal Spine Health Center, PLLC and Associates to use my name, address, phone numbers, photo and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.
I give permission to Ideal Spine Health Center, PLLC and Associates 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 or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.
By signing the following you are giving Ideal Spine Health Center, PLLC and Associates permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a notice of information practices 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.

Signature of Patient/or Guardian:_____ **Date:** _____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable, benefit 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 artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine 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 findings 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 my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or legal Guardian Signature	Date
_____	_____
Witness Signature (office staff)	Date

NEW PATIENT: HISTORY OF PRIMARY COMPLAINTS

Name_____ Date _____

Is this the first time you have had this pain? [ ] Yes [ ] No If No, when was the FIRST time you had these same symptoms? _____

How did the CURRENT episode of pain/discomfort occur?_____

_____

How did the FIRST episode of pain/discomfort occur? _____

_____

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain Location:_____	Pain Location:_____	Pain Location:_____	Pain Location:_____
RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10	RIGHT NOW: _____/10
At its WORST: _____ / 10	At its WORST: _____ / 10	At its WORST: _____ / 10	At its WORST: _____ / 10
At its BEST: _____ / 10	At its BEST: _____ / 10	At its BEST: _____ / 10	At its BEST: _____ / 10
At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10

What makes your pain DIMINISH? (check all that apply):

[ ] Nothing [ ] Ice [ ] Heat [ ] Massage/Rubbing [ ] Exercise/Activity [ ] Sitting
[ ] Standing [ ] Rest [ ] Stretching [ ] "Popping" the joints [ ] Bracing/taping [ ] Laying
[ ] Other: _____
[ ] Over-The-Counter Medications:_____
[ ] Prescription Medications: _____

What makes your pain WORSE? (check all that apply):

[ ] Coughing [ ] Sneezing [ ] Bearing Down [ ] Sexual Intercourse [ ] Running [ ] Standing
[ ] Lifting [ ] Bending [ ] Pushing [ ] Pulling [ ] Driving [ ] Sitting
[ ] Walking [ ] Laying down [ ] Movement of the head [ ] Movement of the low back
Other: _____

Would you describe your pain as:

Location: _____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
Location: _____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
Location: _____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom

Pain Quality: How would you describe your pain/discomfort (check all that apply):

[ ] Dull [ ] Achy [ ] Stiff [ ] Intense [ ] Throbbing [ ] Sharp [ ] Sharp with movement
[ ] Stabbing [ ] Shooting [ ] Burning [ ] Constricting [ ] Annoying [ ] Tight [ ] Unbearable
Other:_____

Radiating: Does your pain seem to radiate from the primary area: [ ] Yes [ ] No If Yes, where does the pain radiate to?

_____

Numbness/Tingling (pins and needles): Do you experience or have you recently experienced numbness and or tingling anywhere? [ ] No [ ] Yes: Please describe where and when you feel these symptoms: _____

_____

Is your pain/discomfort WORSE:
[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day

Is your pain/discomfort BETTER:
[ ] In the morning
[ ] In the afternoon
[ ] In the evening
[ ] While sleeping
[ ] While awake
[ ] It does not seem to be affected by the time of day

Doctor Name: _____ Doctor Signature: _____

Patient Name: _____

Office Use: New Patient / ReExam 1 / 2 / 3

Please indicate if you currently have, or have had in the past, any of the following conditions. If this is a re-exam, please list percentage of improvement from initial visit. ___/12 visits

Instructions for Re Exam 1, 2, 3 ONLY Please write B = Better W = Worse & percentage in highlighted boxes.

Example: Neck pain	Past	Current	% Change	
Neck pain		X	50%	(% Change only if this is a re-exam)

CERVICAL SPINE (NECK): **(X) for past or current**

	Past	Current	% Change
1. Neck pain			
2. Arthritis in neck			
3. Headaches			
4. Pain into shoulder/arm/hands			
5. Numb/tingling in arms/hands			
6. Coldness in hands			
7. Weakness in grip			
8. TMJ/pain/clicking			
9. Low energy/fatigue			
10. Thyroid conditions			

(X) for past or current

	Past	Current	% Change
11. Immune system weakness			
12. Autoimmune Disease			
13. Sinusitis			
14. Recurrent colds/flu			
15. Allergies/hay fever			
16. Dizziness/fainting			
17. Depression			
18. Anxiety			
19. Visual disturbances			
20. Hearing disturbances			

THORACIC SPINE (UPPER BACK):

	Past	Current	% Change
21. Upper back pain			
22. Shoulder pain			
23. Pain w/ inspiration/expiration			
24. Shortness of breath			
25. Asthma/wheezing			
26. Lung infections/bronchitis			

	Past	Current	% Change
27. High blood pressure			
28. Tachycardia			
29. Heart palpitations			
30. High cholesterol			
31. Heart attacks/angina			
32. Heart murmurs			

THORACIC SPINE (MID BACK):

	Past	Current	% Change
33. Mid back pain			
34. Pain into ribs/chest			
35. Scoliosis			
36. Acid reflux			
37. Indigestion/Heartburn			
38. Ulcers/gastritis			

	Past	Current	% Change
40. Hypoglycemia			
41. Nausea			
42. Liver disease			
43. Gall bladder problems			
44. Kidney disease			
45. Diabetes			

39. Tired/irritable after eating or when you haven't eaten for a while -->>>>>>>>>>>>>>>>>>>>>>>>>

LUMBAR SPINE (LOW BACK):

	Past	Current	% Change
46. Low back pain			
47. Pain into hips/knees/legs/feet			
48. Numbness/tingling in legs/feet			
49. Coldness in your legs/feet			
50. Muscle cramps in legs/feet			
51. Weakness/injuries in hips/legs			

	Past	Current	% Change
52. Frequent/difficulty urinating			
53. Bladder/urinary tract infect.			
54. Menstrual irreg./cramps			
55. Constipation			
56. Diarrhea			
57. Sexual dysfunction			

Please list any health conditions not mentioned: _____

_____

Have you ever been diagnosed with cancer? Yes No If yes, explain: _____

Doctor NAME (PRINT): _____ Doctor NAME (SIGN): _____ Date: _____

IDEAL SPINE
HEALTH CENTER

IDEAL SPINE HEALTH CENTER
Shirlene Harrison, D.C.,
950 E. Riverside Drive
Eagle, ID 83616
(208) 939-2502

CONSENT TO TREAT A MINOR

I, _____, give my consent to Ideal Spine Health Center, PLLC to treat my son/daughter _____ including examination, x-rays and chiropractic care.

Date_____

Parent/Guardian Signature_____

Witness _____