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 we can accept your case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being of file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. By signing this agreement and receiving services here, should this go to collections, you agree to pay collection and attorney fees and to be called by an auto/predictive dialer on your home or cell number.

_____ _____

Patient Signature: Date:

_____ _____

Consent to Treat a Minor: Date:

_____ _____

Guardian or Spouse's Signature of Authorizing Care: Date:

McAllister Chiropractic 4308 Grant Line Rd New Albany, IN 47150 (812) 945 - 3800

Date: _____

PATIENT APPLICATION SURVEY

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

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

Email Address: _____ Cell Phone: ( ) _____

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? _____

Insurance Company (Name): _____ ID Number: _____

Subscriber Name (if different): _____ Subscriber Birth Date (if different): _____ / _____ / _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:_____

Is this condition 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

How often do you experience these symptoms throughout the day?: 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? _____

On a scale of 1-10, with 10 being the highest, how would you rate your commitment towards getting rid of this problem? _____

If we find that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan? Yes No

Concerns: Time, Transportation, Other: Specify: _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? □ Yes □ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

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: _____

Date: _____

HEALTH 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 _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you drink coffee/caffeine drinks? Yes No How many cups / day? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

*Are you pregnant? Yes No Due Date: _____ *Do you have a pacemaker? Yes No *History of Stroke? Yes No Date: _____

HEALTH CONDITIONS

Abnormal postural habits or 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. Subluxations have many serious and adverse affects on your overall health. Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinus Conditions
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

Explain: _____

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ Pain On Deep Inspiration/Expiration
- ❑ Upper Back Pain

THORACIC SPINE (MID BACK):

Postural distortions from subluxations 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…?

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable after eating or when you haven't eaten for a while
- ❑ Diabetes

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

_____