New Adult Practice Member Application

This form is for adults only. Please ask the front desk for our pregnancy or pediatric forms.

Today's Date: ____/____/____ **Age:** _____ **Male / Female** **Date of Birth**_____/_____/_____

Name: _____ **Who may we thank for referring you?** _____

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

Primary Phone: _____ **Email:** _____

For confirming appointments and important updates do you prefer? TEXT or EMAIL

Occupation: _____ **Company Name:** _____

Please indicate if you or your spouse are a: TEACHER/STUDENT FIRST RESPONDER MILITARY/VETERAN

Single / Married / Divorced / Widowed **Spouse's Name:** _____

Are you currently receiving care from any other health professionals? YES / NO

If yes, who, and what is their specialty? _____

Have you ever been adjusted before? YES / NO

If yes, how was your experience?

GOOD / BAD / INDIFFERENT

What would you like to gain from chiropractic care?

☐ Pain Relief ☐ Overall Wellness ☐ Both

What are your health goals?

1. _____
2. _____
3. _____

Current Health Conditions

What is your *PRIMARY* health concern? _____ Onset Date: _____

How often do you experience this issue?

☐ Constant (76-100% of the time) ☐ Frequently (51%-75% of the time)

☐ Occasionally (26-50% of the time) ☐ Intermittently (0-25% of the time)

Please circle any of the following activities that aggravate this condition

Walking Standing Running Sitting Climbing Stairs Lying Down Lifting Twisting Yard Work

Exercising Shoveling Snow Reaching Housework Prolonged Sitting Quick Movement Bending

Please circle any of the following that make this condition better

Adjustments Exercise Massage Stretching Walking Resting Lying Down Other: _____

What does it feel like? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Numb ☐ Other

Average intensity (0 = none, 10 = greatest) Please circle one:

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate? YES / NO

If yes, where does the pain radiate? _____

What is your *SECONDARY* health concern? _____ Onset Date: _____

How often do you experience this issue?

☐ Constant (76-100% of the time) ☐ Frequently (51%-75% of the time)

☐ Occasionally (26-50% of the time) ☐ Intermittently (0-25% of the time)

Please circle any of the following activities that aggravate this condition

Walking Standing Running Sitting Climbing Stairs Lying Down Lifting Twisting Yard Work

Exercising Shoveling Snow Reaching Housework Prolonged Sitting Quick Movement Bending

Please circle any of the following that make this condition better

Adjustments Exercise Massage Stretching Walking Resting Lying Down Other: _____

What does it feel like? ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Numb ☐ Other

Average intensity (0 = none, 10 = greatest) Please circle one:

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate? YES / NO

If yes, where does the pain radiate? _____

Please list any additional concerns you may have:

Health Concerns: (List according to severity)	Rate of Severity 1= Mild 10=Unbearable	When did the Symptoms Start?	Are the Symptoms Constant or Intermittent?
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____
4_____	_____	_____	_____
5_____	_____	_____	_____

Please circle if you are CURRENTLY experiencing:

Neck Pain Mid Back Pain Low Back Pain Vertigo Headaches Sciatica Dizziness Anxiety Hip Pain Depression Nausea Shoulder Pain Migraines Asthma Ulcers Menstrual Irregularities Stomach Disorder Irritable Bowel Thyroid Problems Bladder Complications TMJ Disorder Ear Infection Allergies Infertility Epilepsy Chest Pain Kidney Stones Heart Disorder Chronic Fatigue Gastric Reflux Knee Pain L/R Chronic Sinusitis ADD/ADHD

Numbness in: Face Arms Hands Fingers Legs Feet Toes

Any other health condition not listed above:

_____

_____

Please list all medications, prescriptions, vitamins & supplements you are currently taking:

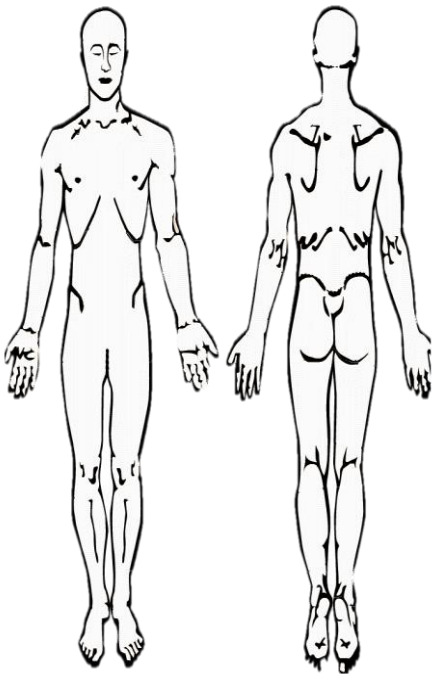
(If you have a list please provide along with this paperwork)

_____

_____

Please rate the following by circling what you perceive is true for yourself in each area.

Physical Fitness:	Poor	1	2	3	4	5	Excellent
Energy Levels:	No Energy	1	2	3	4	5	Very Energetic
Flexibility:	Can't Move	1	2	3	4	5	Very Flexible
Nutritional Health:	Poor	1	2	3	4	5	Excellent
Emotional Health	Poor	1	2	3	4	5	Excellent



Past Health History

Please circle any of the following conditions you have experienced:

Stroke, Cancer, Heart Disease, Spinal Surgery, Seizures,

Spinal Bone Fracture, Scoliosis, Diabetes, Infections, Miscarriages

List all surgical operations: _____

When was your last leisure, auto, home, or work accident?

_____/_____/_____/_____/_____

Have you ever been knocked unconscious? YES / NO Fractured a bone? YES / NO

_____

_____

If your CURRENT condition was caused by an accident, please describe what happened the best you can:

_____

_____

_____

Is there anything additional you would like to add that you feel our doctor needs to know about?

_____

_____

_____

Notice of Privacy Practices Acknowledgment

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

1. Conduct, plan, and direct my care 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 care, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I request and authorize Cornerstone Family Chiropractic to release my health information to the following parties:

Name: _____ **Relationship to me:** _____

Name: _____ **Relationship to me:** _____

Signature _____ **Date:** _____/_____/_____
(Required)

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 the x-rays in our files. Additional requests for copies may have an associated fee.

Please note: x-rays are utilized primarily in this office to help locate and analyze the presence of vertebral subluxations. These x-rays are not used to investigate for medical pathology. 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 & CONDITIONS

Print _____

Signature _____ **Date:** _____/_____/_____
(Required)

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT CORNERSTONE FAMILY CHIROPRACTIC.

Signature (Required) _____ **Date:** _____/_____/_____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both the Doctor and the patient to be working towards the same objective.

Our main goal is to help your body (specifically your spine and nervous system) become more mobile, adaptable, and functional. When this is achieved often times you will feel better as a result. It is important that each practice member understand both the objective and the method that will be used to ascertain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine or extremities.

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

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 its maximum health potential.

Our main goals and objectives are to locate and correct vertebral subluxations of the spine. Chiropractic is not designed to make you instantly feel better, rather the chiropractic method is and has always been to improve your body's ability to adapt and cope with both the internal and external stresses. We have laid out clear objective and subjective measures for care. During active care we will actively measure subjective and objective improvement through various ways of measurement. Once discharged from active care you will be given the opportunity to continue with supportive or maintenance care (both supportive and maintenance care are not covered by insurance). At any time during your care with us, if we find unusual finding or are unable to reach any of the subjective or objective goals set, we will provide a referral to a care provider better suited to care for that specific need. We do not offer any other services besides chiropractic care in our office. It is your responsibility to be consistent with the at home instructions that our doctors provide.

FIRST DAY COSTS: You will be responsible to pay in full for all first day costs including co-pays prior to leaving; including but not limited to: evaluations, x-rays, first day adjustments. Unless our office staff has in writing any other arrangement for payment. First day adjustment pricing does differ from adjustment pricing that will be built into your care plan. We will disclose any and all pricing prior to rendering services.

I, _____ have read & fully understand the above statements.
Print Name

Signature _____ **Date:** _____/_____/_____
(Required)

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, but not limited to: sprain/strain injuries, irritation of a disc condition, fractures. One of the rarest complications associated with chiropractic care occurring at a rate of one instance per 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 this 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 findings will be provided to you along with a care plan prior to beginning care.
I understand and accept that there are risks associated with chiropractic care and I give full consent to the examination that the doctor deems necessary and the chiropractic care including: spinal adjustments, therapies, and evaluations as reported following my initial assessment.
If you do not wish to have ANY part of your spine checked and adjusted, please do not sign and notify either one of the chiropractic assistants or the doctor to discuss your concern prior to receiving care.

Print _____

Signature _____ **Date:** _____/_____/_____
(Required)

_____
Witness Signature (Office Staff)

Practice Member Insurance Information

(Must be Completed Before Services Can Be Rendered)

SOCIAL SECURITY NUMBER: _____

CONTACT IN CASE OF EMERGENCY: _____

Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER:

_____

Name of Insured_____

Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER:

_____

Name of Insured_____

Date of Birth _____

Insured Social Security Number: _____

Signed_____

Date_____

Insurance Policies and Fee Schedule

- Consultation- includes practice member history. This service is complimentary
- Assessment (new or established practice member)- includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, HRV, leg check $50-$250.
- Chiropractic Adjustment- The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $35-$65.
- X-rays- Specific x-ray views taken of your spine to help determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $50-$300.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Cornerstone Family Chiropractic. 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 patient. 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.