T 1 2 3

Time In:_____
Time Out:_____

NEW PRACTICE MEMBER APPLICATION

Name_____**Date of Birth**____ /_____ /_____**Age**_____**Male/Female**

Address_____**City**_____**State**_____**Zip**_____

Phone: Cell_____ **Home**_____

Email Address_____

Occupation_____**Employer's Name**_____

Are you a student? YES ☐ NO ☐ **Have you ever been in the military? YES ☐ NO ☐**

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

Number of Children_____ **Names, Ages & Gender**_____

Who may we thank for referring you? _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Health Concern: List according to severity	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:_____	_____	_____	_____	_____	_____
Second:_____	_____	_____	_____	_____	_____
Third:_____	_____	_____	_____	_____	_____
Fourth:_____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR?_____**MEDICAL DOCTOR?**_____**OTHER**_____

WHO AND WHEN?_____

WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain) _____

_____

MARK "C" FOR CURRENT OR MARK "P" FOR IN THE PAST. (over 1 year ago) IF NOT APPLICABLE, PLEASE LEAVE BLANK:

___ *Headaches*	___ *Ear Infections*	___ *Sinus Issues*	___ *Kidney Problems*	___ *Sexual Dysfunction*
___ *Migraines*	___ *Hearing Loss*	___ *Frequent Colds*	___ *Bladder Problems*	___ *Sleep Problems*
___ *Neck Pain*	___ *Ringing in the Ears*	___ *Thyroid Issues*	___ *Menstrual Problems*	___ *Tight/Sore Muscles*
___ *Shoulder Pain*	___ *Dizziness*	___ *Asthma*	___ *Prostate Problems*	___ *Sports Injury*
___ *Arm Pain*	___ *Loss of Energy*	___ *Chest Pain*	___ *Infertility*	___ *TMJ/Jaw Pain*
___ *Upper Back Pain*	___ *Nervousness*	___ *Heart Problems*	___ *Fibromyalgia*	___ *Arthritis/Joint Pain*
___ *Mid Back Pain*	___ *Double/Blurry Vision*	___ *Nausea*	___ *Epilepsy/Convulsions*	___ *GERD/Gastric Reflux*
___ *Lower Back Pain*	___ *Anxiety*	___ *Ulcers*	___ *Tremors*	___ *Numb/Tingling in Arms/Hands*
___ *Hip/Leg Pain*	___ *ADD/ADHD*	___ *Digestive Issues*	___ *Disc Problems*	___ *Numb/Tingling in Legs/Feet*
___ *Sciatica*	___ *Loss of Balance*	___ *Diarrhea*	___ *Scoliosis*	___ *Stomach Problems*
___ *Knee Pain*	___ *Depression*	___ *Constipation*	___ *Poor Posture*	___ *High/Low Blood Pressure*
___ *Foot Pain*	___ *Allergies*	___ *Bed Wetting*	___ *Skin Problems*	___ *Difficulty Breathing*

*Other:*_____

Name:_____

MARK "C" FOR CURRENT OR "P" FOR PAST. IF NOT APPLICABLE, PLEASE LEAVE BLANK:

___STROKE ___ CANCER ___HEART ATTACK ___SPINAL SURGERY ___SEIZURES ___SPINAL BONE FRACTURE ___SCOLIOSIS
___DIABETES ___OSTEOARTHRITIS ___RHEUMATOID ARTHRITIS ___OTHER CONDITIONS/DISEASES

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

_____

LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT?_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES/NO

IF YOU HAVE, DR. & DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES/NO FRACTURED A BONE? YES/NO

IF YES TO EITHER OF THE ABOVE, PLEASE DESCRIBE:_____

OTHER TRAUMA:_____

SOCIAL HISTORY

1. SMOKING: How often? □ Daily □ Weekends □ Occasionally □ Never
2. ALCOHOL: How often? □ Daily □ Weekends □ Occasionally □ Never
2. EXERCISE: How often? □ Daily □ Weekends □ Occasionally □ Never
3. How does your present problem affect the following: HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE

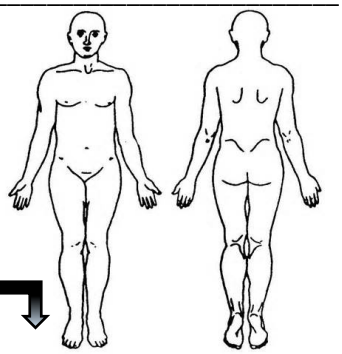
_____
_____

FAMILY HEALTH HISTORY:

Please list any pertinent and applicable family health history of which we should be aware:

_____
_____

***PLEASE MARK** the areas on the diagram with the following **LETTERS** to describe your symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling



What relieves your symptoms?_____
What makes them feel worse?_____

List Your Current Health Goals Below

HEALTH GOAL	DATE TO ACCOMPLISH	SIGNIFICANCE OF GOAL
Ex: Get rid of my headaches	1/1/2016	I want to play with my kids without pain, be able to spend more time with my family and have more energy.
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

ACTIVITIES OF DAILY LIVING

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

ACTIVITY:	EFFECT:			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	❑ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Signature: _____ Date____ /_____ /_____

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

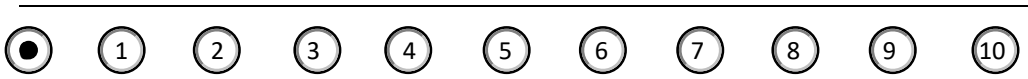
Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:

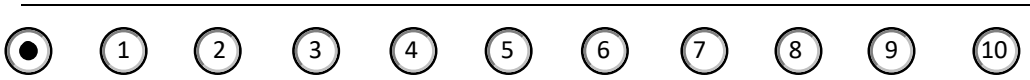
No pain _____Worst possible pain

0 1 2 3 4 5 6 (7) 8 9 10

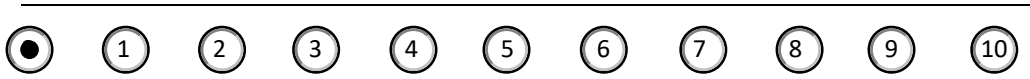
1. How would you rate your pain RIGHT NOW?



2. What is your typical or AVERAGE pain?

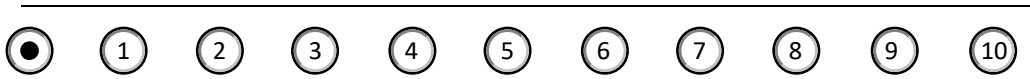


3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1____+Q2____+Q4____=____ /3x10=____ (Low Intensity = <50; High Intensity = >50)

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 SCONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO 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 THE CHIROPRACTIC 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 FINDING 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 CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBERS NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE OR GUARDIAN SIGNATURE **DATE**

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. TAYLOR SIROIS AND ANY AND ALL RESTORATION CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.
AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY RESTORATION CHIROPRACTIC.

_____ _____

DATE GUARDIAN SIGNATURE **AND** RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

TERMS OF ACCEPTANCE

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

- By my signature below, I have read and fully understand the above statements.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

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

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

_____ _____

(Signature) **(Date)**

File #:_____
DOB:___/___/_____

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 YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS IS $15 PER VIEW AND WILL BE EMAILED. THIS FEE MUST BE PAID IN ADVANCED.

DIGITAL X-RAYS ON CD WLL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY. **PLEASE NOTE:** X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, 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 AND CONDITIONS.

_____ _____

PRINT YOUR NAME HERE **DATE**

_____ _____

SIGNATURE **DATE OF BIRTH**

FEMALE PRACTICE MEMBERS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME THE X-RAYS ARE TAKEN AT RESTORATION CHIROPRACTIC.

_____ _____

SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE

Sex: □ M □ F

□ Lat Cervical □ Flex/Ext

CM	Kvp	Time	MAS
□10-11	□ 78	□1/24	12.5
□12-13	□	□1/20	15
□14-15	□	□1/15	20
□16-17	□	□1/10	30
		□2/15	40

MA 300 SIZE 8X10

□ Lower Cervical

CM	Kvp	Time	MAS
□14-15	□70	□1/10	20
□16-17	□	□2/15	30
□18-19	□	□3/20	40
□20-21	□	□2/10	50
□22-23			

MA 300 SIZE 8X10

□ APOM

CM	Kvp	Time	MAS
□14-15	□70	□1/10	20
□16-17	□	□2/15	30
□18-19	□	□3/20	40
□20-21	□	□2/10	50
□22-23			

MA 300 SIZE 8X10

Other
View_____

CM_____Kvp_____

MAS____MA_____

Size_____

□ Lateral Thoracic

CM	Kvp	Time	MAS
□22-23	□80	□1/15	20
□24-25	□	□1/10	30
□26-27	□	□2/15	40
□28-29	□	□2/10	50
□30-31	□	□1/4	75
□32-33	□	□3/10	90
□34-35	□	□2/5	120
□36-37	□	□1/2	150

MA 300 SIZE 14X17

□ A-P Thoracic

CM	Kvp	Time	MAS
□16-17	□75	□1/20	17
□18-19	□	□1/15	22
□20-21	□	□1/10	30
□22-23	□	□2/15	40
□24-25	□	□2/10	50
□26-27	□	□1/4	75
□28-29	□	□3/10	90
□30-31	□	□2/5	120

MA 300 SIZE 14X17

□ Lateral Lumbar

CM	Kvp	Time	MAS
□26-27	□88	□2/10	30
□28-29	□90	□1/4	40
□30-31	□92	□3/10	50
□32-33	□94	□2/5	70
□34-35	□96	□1/2	90
□36-37	□	□3/5	120
□38-39	□	□4/5	160
□40-41	□	□1	200
□42-43	□	□1 1/2	

MA 200 SIZE 14X17

□ A-P Lumbar

CM	Kvp	Time	MAS
□20-21	□76	□1/15	40
□22-23	□78	□1/10	50
□24-25	□80	□2/15	75
□26-27	□	□2/10	90
□28-29	□	□1/4	120
□30-31	□	□3/10	150
□32-33	□	□2/5	120
□34-35	□	□1/2	170
□36-37	□	□3/5	210
□38-39	□	□4/5	
□40-41	□	□1	
□42-43	□	□1 1/2	

MA 300 SIZE 14X17

Notes: _____
_____
_____
_____
_____
_____