



Highest Health c h i r o p r a c t i c

NEW PRACTICE MEMBER APPLICATION

Today's Date: _____

Name _____ Date of Birth ____/____/____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Phone: Cell _____ Home _____

Social Security #: _____ Driver's License #: _____

Email: _____

Occupation _____ Employer's Name _____

Name of Emergency Contact: _____ Phone #: _____

Relationship: _____ Who may we thank for referring you? _____

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

Spouse's Employer: _____ Number of Children _____

Names, Ages, & Gender _____

List The Health Concerns That Brought You Into This Office

Health Concern(s):
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

If Yes: Chiropractor Medical doctor Other _____

Who? _____ When? _____ Results? _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

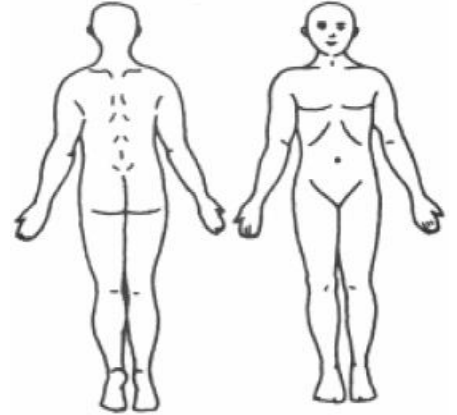
- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Migraines | <input type="checkbox"/>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

Pregnant: Due Date?: _____ Stroke Cancer Heart Attack Spinal Surgery

Spinal Bone Fracture Scoliosis Diabetes Arthritis Seizures Other: _____

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching
N = Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms?

What makes your symptoms feel worse?

When is the problem(s) at its worst? → AM PM Mid-Day Late PM

Please identify any & ALL types of jobs you have had in the past that have imposed any physical stress on your body:

List all surgical operations & 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, & the reason for each:

Have you ever been in an auto accident?
List all: _____

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
- 3. Exercise: How often? Daily Weekends Occasionally Never
- 4. Recreational Drug Use: How often? Daily Weekends Occasionally Never
- 5. Have you consumed any caffeine or products with caffeine in the past 48 hours? Yes No

Practice Member or Authorized Person's Initials

Date Completed

QUADRUPLE VISUAL ANALOGUE SCALE

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 _____ Back pain _____ Headaches _____ Worst possible pain _____
 0 1 2 3 **4** 5 6 **7** 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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?)

0 1 2 3 4 5 6 7 8 9 10

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

Practice Member or Authorized Person's Initials

Date Completed

ACTIVITIES OF LIFE

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

ACTIVITY:

EFFECT:

Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Example: Climbing stairs LIST RESTRICTED ACTIVITY	I can climb 2 flights before it hurts CURRENT ACTIVITY LEVEL	I used to climb 10+ flights without pain USUAL ACTIVITY LEVEL
---	--	---

Practice Member or Authorized Person's Initials	Date Completed
---	----------------

FAMILY HEALTH HISTORY

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

Practice Member or Authorized Person's Initials

Date Completed

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 physicians 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: _____

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 the doctors and any and all Highest Health 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 Highest Health Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Practice Member or Authorized Person's Initials

Date Completed

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: 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 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.
- I authorize and request payment of insurance benefits directly to the doctors at Highest Health 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 practice member. 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. This pertains to any and ALL services rendered.

Print Name: _____ Date: _____

Practice Member Signature : _____ Date: _____

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. Digital x-rays on a CD will be available within 72 hours of request on any regular practice day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Highest Health 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 Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY ↓: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Highest Health Chiropractic.

The first day of my last menstrual cycle was on _____-_____-_____ (Date)

↓ Doctor Use Only ↓

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature _____