

APEX CHIROPRACTIC

New Practice Member Form

Name: _____ Date: _____

Age: _____ Birthday: ____/____/____

Male Female

Address: _____

City: _____ State: _____ Zip: _____

I am: Single Married Divorced Widowed

Spouse's Name: _____ # of Children: _____

Child's Name: _____ Age: _____

Child's Name: _____ Age: _____

Child's Name: _____ Age: _____

Emergency Contact: _____

Phone #: _____

Contact Information

Home Phone: _____

Cell Phone: _____

Email: _____

Employment

Employer: _____

Occupation: _____

From Whom or Where/How did you hear about Apex Chiropractic?

My Main Health Concerns

A

B

C

Issue: _____

Started: _____



Issue: _____

Started: _____



Issue: _____

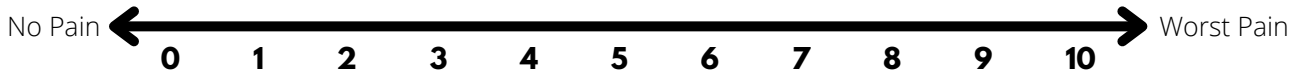
Started: _____



Quadruple Visual Analogue Scale

Please write the corresponding letter to each of your main health concerns above (A, B, C) on the scale for each of the four questions below.

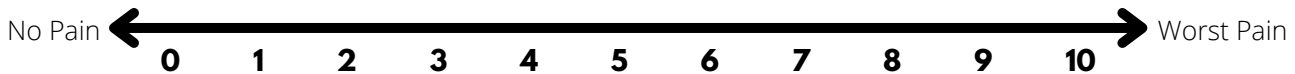
- How would you rate your pain RIGHT NOW? ↷



- What is your TYPICAL or AVERAGE pain? ↷



- What is the LEAST your pain ever is? ↷



- What is your pain level at its WORST? ↷



Any other health concerns you are dealing with?

Please mark "C" for issues you are currently dealing with or "P" for things you have dealt with in the past.

- | | | | |
|---------------|------------------------|---------------------|----------------------|
| ___ Headaches | __ Ear Infections | __ Sinus Problems | __ Arm/Hand Numbness |
| ___ Migraines | __ Asthma | __ Epilepsy | __ Leg/Foot Numbness |
| ___ Dizziness | __ High Blood Pressure | __ Heart Disorder | __ Sciatica |
| ___ Vertigo | __ Chronic Fatigue | __ Digestive Issues | __ Carpal Tunnel |
| ___ Nausea | __ Chest Pain | __ Bladder Problems | __ Kidney Problem |
| ___ Anxiety | __ Nervousness | __ Menstrual Issues | __ Thyroid Problem |
| ___ Allergies | __ ADD/ADHD | __ TMJ Pain | __ Fibromyalgia |

Habe you ever seen other doctors for these conditions? Yes No

If yes, what provider & when: _____

Name of your Primary Care Physician: _____

Check any conditions you have now/have had:

- | | | | |
|---------------|--------------|-------------------|--------------------------|
| ___ Stroke | ___ Cancer | ___ Heart Disease | ___ Spinal Surgery |
| ___ Scoliosis | ___ Diabetes | ___ Seizures | ___ Spinal Bone Fracture |

List all surgical operations & years: _____

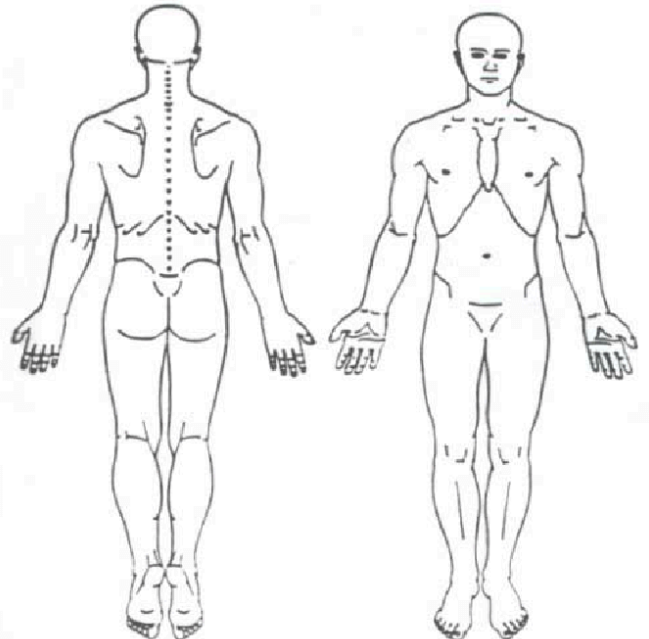
List all over-the-counter & prescription medications you are on and the reason for each: _____

Were you ever in a car accident? If so, when? _____

Body Diagram

Please mark the areas on the diagram with the following letters to describe your symptoms:

- R - Radiating
- N - Numbness
- B- Burning
- S - Sharp/Stabbing
- D - Dull
- T - Tingling



¿What relieves your symptoms? _____

What worsens your symptoms? _____

Social History:

How often do you do each of the following?

- Smoking..... Daily Weekly Occasionally Never
- Recreational Drug Use..... Daily Weekly Occasionally Never
- Alcohol..... Daily Weekly Occasionally Never

Activities of Daily Living:

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

	No Effect	Painful (can do)	Painful (limited)	Unable to Perform
Lift/Carry Heavy Objects				
Walk				
Run				
Sit				
Stand				
Sit to Stand Motion				
Exercise				
Climb Stairs				
Pet Care				
Household Chores				
Eat				
Sleep				
Personal Care				
Concentrate				
Use Technology				
Driving				
OTHER:_____				

Last But Not Least!

What is your goal to achieve through
Chiropractic Care??



My Goal! ↘

*Sleep Better?
Spend more time
with my family,
doing the things
I love?*

Exercise without pain?



By signing below, I acknowledge that I have filled out the Apex Chiropractic New Practice Member Form accurately and to the best of my ability.

Print Name: _____ Signature: _____ Date: _____

Note of Privacy Practices Acknowledgement

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances.

Permitted Disclosures:

- Treatment purposes - discussion with other health care providers involved in your care
- Inadvertent disclosures - open treating area means open discussion, If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room
- For payment purposes - to obtain payment from your insurance company or any other collateral source
- For worker's compensation purposes - to process a claim or aid in investigation
- Emergency - in the event of a medical emergency, we may notify a family member
- For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
- To governmental agencies or law enforcement - to identify or locate a suspect fugitive, material witness, or missing person
- Deceased persons - discussion with coroners and medical examiners in the event of a patient's death
- Telephone calls or emails and appointment reminders - we may call you home/cell and leave voice/text messages regarding an appointment, a missed appointment, or notify you of changes in practice hours or upcoming events
- Announcing names in queue at the front desk & reception area - we announce the first and last names of patients in queue that are waiting to be treated(eg. "Jane Smith, please proceed to room 2"). Please notify the office manager if you would like this to be changed
- Change of ownership - in the event this practice is sold, the new owners would have access to your Personal Health Information

Your rights:

- To receive an accounting of disclosures
- To receive a paper copy of the comprehensive Detail Privacy Notice
- To request mailings to an address different than residence
- To request restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.

Terms of Acceptance

In order to provide the most effective healing environment, the most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is essential for both parties to be working towards the same objective. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

- Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. It is not the practice of medicine.
- Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustments of vertebral subluxation(s). Subluxations are deviations from normal spinal structures and configurations, and considered to be a partial dislocation. A subluxation that interferes with normal nerve processes is called a neurostructural shift.
- 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 a day with doctor of chiropractic in the United States alone.
- 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.

No-Show, No- Communication Fee Policy

At Apex Chiropractic, we highly value your time and we are fully committed to your success. We also ask that our practice members do the same to provide the best experience possible for everyone. To ensure this, our no-call no-show policy will involve the following: Any missed appointment with no contact from the practice member, we will bill your account \$50 for not keeping your scheduled appointments, and taking a spot that someone else could have utilized. After 3 missed appointments in a row, your future appointments will be removed until contact is made.

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 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 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, and 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.

By signing below:

- 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 Dr. Kamen Blau. 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 the services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by his assignment.

By Signing below, you are acknowledging and agreeing to all statements listed above and on the previous page.

*Print Name: _____ Signature: _____ Date: _____

If this health profile is for a minor/child, please fill out and sign below

Name of Practice Member Who is a Minor/Child: _____

I authorize Dr. Kamen Blau, and any and all Apex Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor/child as legally allowed. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority care is revoked or altered, I will immediately notify Apex Chiropractic.

Guardian Signature _____ Guardian Relationship to Child _____ Date _____

I give permission for Apex Chiropractic to contact me by email regarding my healthcare, appointments, and related information. I understand that email is used for convenience and that while reasonable safeguards are used, it may not always be fully secure.

Signature: _____ Date: _____