



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

Patient Signature: _____

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? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____
Is this purpose related to an auto accident / work injury? ___Yes ___No If so, when: _____
Describe: _____
Please describe the pain and its location: _____
When did this condition begin? ____/____/____ When did you first notice it? _____
Is this condition getting worse? ___Yes ___No Is this condition: ___Constant ___Comes and Goes ___Activity Related
Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain: _____
What activities aggravate your symptoms? _____
Is there anything, which has relieved your symptoms? ___Yes ___No Describe: _____
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? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ___Yes ___No Who? _____ When? _____
Reason for visits: _____
How did you respond? _____
Did your previous chiropractor take BOTH before and after care X-rays? ___Yes ___No
Did you know that posture determines your health? ___Yes ___No
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: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or feel like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? ___Yes ___No

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

Other exercise _____

Do you smoke? Yes No How much? _____

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

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

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

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. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Migraines / Headaches | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pain into shoulders/arms/hands | <input type="checkbox"/> Dizziness / Brain Fog | <input type="checkbox"/> Allergies/Hay Fever |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Recurrent Colds/Flu |
| <input type="checkbox"/> Hearing Disturbances | <input type="checkbox"/> Coldness in Hands | <input type="checkbox"/> Low Energy/Fatigue |
| <input type="checkbox"/> Weakness in grip | <input type="checkbox"/> Thyroid Conditions | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Insomnia/Sleeping Problems | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Depression |

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the heart and lungs and affect these parts of your body. Do you experience...?

- | | |
|--|---|
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Recurrent Lung Infections / Bronchitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Asthma / Wheezing |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Attacks / Angina | <input type="checkbox"/> Pain on Inspiration / Expiration |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Pneumonia |

THORACIC SPINE (MID BACK):

Postural Distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest, adrenal glands and upper digestive tract, and affect these parts of your body. Do you experience...?

- | | |
|--|--|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain into Ribs / Chest | <input type="checkbox"/> Ulcers / Gastritis |
| <input type="checkbox"/> Indigestion / Heartburn | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Tired/Irritable after eating or when hungry |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia |

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your hips/legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- | | | |
|---|--|--|
| <input type="checkbox"/> Pain into hips / legs / feet | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Numbness / tingling in legs / feet | <input type="checkbox"/> Recurrent bladder infections | |
| <input type="checkbox"/> Coldness into legs / feet | <input type="checkbox"/> Frequent / difficulty urinating | |
| <input type="checkbox"/> Muscle cramps in legs / feet | <input type="checkbox"/> Menstrual irregularities / cramping (females) | |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Sexual Dysfunction | |

Please list any health conditions not mentioned: _____

Please list any medications / surgeries: _____

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Gall bladder |
| <input type="checkbox"/> Broken Bones/Fractures | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Other: _____ | | | |

AUTHORIZATION FOR CARE

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit of these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or physical therapist for all services rendered.

 Patient's Name Printed Date Patient's Signature Date

 Minor's Name Guardian/Spouse's Signature of Authorizing Care for Minor Date

IN CASE OF EMERGENCY

Name _____
 Relationship _____
 Work Phone _____
 Home Phone _____
 Cell Phone _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case I will be fully informed of the charges I will owe prior to services being rendered. I understand I may choose not to receive such services.

Patient's Signature _____ Date _____

Guardian of Spouse's Signature Authorizing Care _____ Date _____

I hereby authorize Advanced Wellness Center to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____ Policy # _____

Address _____ Phone # _____

Insured's Name _____ Insured's SS# _____

Relationship to Insured _____ Birthdate ____/____/____

Employer _____

Who should receive charges on your account?

- Patient Spouse Parent/Guardian Worker's Comp Auto Insurance
 Medicare Personal Health Insurance

*NOTE – If your insurance coverage or company changes, it is your responsibility to provide us with your new policy information when it goes into effect. Failure to do so could result in your being responsible for charges of denied bills.

RADIOGRAPHIC CONSENT

I _____ do hereby give my consent to allow Advanced Wellness Center and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

FEMALE ONLY I also hereby declare that to my knowledge I am not pregnant _____ (Initial)

Signature of Patient or Guardian of said Minor _____ Date _____

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES ADVANCED WELLNESS CENTER TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS.

I give permission to Advanced Wellness Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mail messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Advanced Wellness Center to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Advanced Wellness Center permission to use and disclose your protected health information in accordance with the directives listed above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- * The right to review the notice prior to signing this consent
- * The right to object to the use of my health care information for directory purposes
- * The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Analysis: CBP/Pettibon

Diagnosis: (1)_____ (2)_____ (3)_____ (4)_____ (5)_____ (6)_____

Patient Accepted for Postural Corrective Care Yes No Referred out _____

Doctor's Signature _____ Date _____

RAND 36 ITEM HEALTH SURVEY 1.0

Patient Name: _____

- | | |
|---|---|
| <p>1. In general, would you say your health is:
(Circle One Number)</p> | <p>Excellent.....1
Very Good.....2
Good.....3
Fair.....4
Poor.....5</p> |
| <p>2. Compared to one year ago, how would you rate your:
general health right now ?
(Circle One Number)</p> | <p>Much better than one year ago.....1
Somewhat better than one year ago.....2
About the same.....3
Somewhat worse now than one year ago 4
Much worse now than one year ago.....5</p> |

<p>The following items are about activities you might do during a typical day: Does your health now limit you in these activities ? If so, how much ? (Circle One Number on Each Line)</p>	<p>Yes, Limited A Lot</p>	<p>Yes, Limited A Little</p>	<p>No, Not Limited at All</p>
---	--	---	--

- | | | | |
|---|--|--|--|
| <p>3. Vigorous activities, such as running, lifting heavy objects,
participating in strenuous sports.....</p> <p>4. Moderate activities, such as moving a table pushing a vacuum
cleaner, bowling or playing golf.....</p> <p>5. Lifting or carrying groceries.....</p> <p>6. Climbing several flights of stairs.....</p> <p>7. Climbing one flight of stairs.....</p> <p>8. Bending, kneeling or stooping.....</p> <p>9. Walking more than a mile.....</p> <p>10. Walking several blocks.....</p> <p>11. Walking one block</p> <p>12. Bathing or dressing yourself.....</p> | <p>1
1
1
1
1
1
1
1
1
1
1</p> | <p>2
2
2
2
2
2
2
2
2
2
2</p> | <p>3
3
3
3
3
3
3
3
3
3
3</p> |
|---|--|--|--|

<p>During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health ? : (Circle One Number on Each Line)</p>	<p>Yes</p>	<p>No</p>
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- | | | |
|--|----------------------------|----------------------------|
| <p>13. Cut down the amount of time you spend on work or other activities</p> <p>14. Accomplish less than you would like.....</p> <p>15. Were limited in the kind of work or other activities.....</p> <p>16. Had difficulty performing the work or other activities (for example, took extra effort)</p> | <p>1
1
1
1</p> | <p>2
2
2
2</p> |
|--|----------------------------|----------------------------|

<p>During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems ? : (depressed, anxious) (Circle One Number on Each Line)</p>	<p>Yes</p>	<p>No</p>
---	-------------------	------------------

- | | | |
|--|----------------------------------|----------------------------------|
| <p>17. Cut down the amount of time you spend on work or other activities</p> <p>18. Accomplish less than you would like.....</p> <p>19. Didn't do work or other activities as carefully as usual.....</p> <p>20. During the past 4 weeks, to what extent has your physical health or emotional:
problems interfered with your normal social activities with family, friends,
neighbors or groups?
(Circle One Number)</p> | <p>1
1
1
1
1</p> | <p>2
2
2
2
2</p> |
|--|----------------------------------|----------------------------------|

21. How much **bodily** pain have you had during the **past 4 weeks**:
(Circle One Number)
- None.....1
Very Mild.....2
Mild.....3
Moderate.....4
Severe.....5
Very Severe.....6
22. During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework ?
(Circle One Number)
- Not at all.....1
Slightly.....2
Moderately.....3
Quite a bit.....4
Extremely.....5

These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . . (Circle One Number on Each Line)	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
23. Did you feel full of pep ?.....	1	2	3	4	5	6
24. Have you been a very nervous person ?.....	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up ?.....	1	2	3	4	5	6
26. Have you felt calm and peaceful ?.....	1	2	3	4	5	6
27. Do you have a lot of energy ?.....	1	2	3	4	5	6
28. Have you felt downhearted and blue ?.....	1	2	3	4	5	6
29. Did you feel worn out ?.....	1	2	3	4	5	6
30. Have you been a happy person ?.....	1	2	3	4	5	6
31. Did you feel tired ?	1	2	3	4	5	6

32. During the **past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities like visiting with family, friends, relatives, etc.?
(Circle One Number)
- All of the time.....1
Most of the time.....2
Some of the time.....3
A little of the time.....4
None of the time.....5

How TRUE or FALSE is each of the following statements for you ?

(Circle One Number on Each Line)	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
33. I seem to get sick a little easier than other people	1	2	3	4	5
34. I am as healthy as anybody I know	1	2	3	4	5
35. I expect my health to get worse	1	2	3	4	5
36. My health is excellent	1	2	3	4	5

Comments: _____

Patient Signature: _____

Date _____