Who may we thank for referring you? _____

# Clermont Chiropractic Life Center

APPLICATION FOR CARE

Todays Date: _____/_____/_____ Marital Status: Married Single Divorced Widowed

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐Male ☐Female

Address: _____ City: _____State: _____ Zip: _____-_____

E-Mail Address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Reminder Preference: ☐Phone Call ☐Text ☐E-Mail

SSN: _____-_____-_____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse: _____ Spouse Occupation: _____

Name and Ages of Children: _____

_____

Are you a year round resident of Central FL? Y or N if no, when and where: _____

Do you have insurance? Y or N (if yes, please give the front desk you insurance card to copy)

**If patient is a minor (under 18 yrs old) Please fill out section, if not, skip**

Parent/ Guardians Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐Male ☐Female

Address: _____ City: _____State: _____ Zip: _____-_____

E-Mail Address: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Spouse: _____ Spouse Occupation: _____

## POSSIBLE CAUSES FOR VERTEBRAL SUBLUXATIONS

Our patients have had literally dozens of impacts *(car accidents, slips, falls, birth process)* that could cause subluxation. Help us discover yours.

1. Auto Accidents: please list all accidents (birth to present, your fault or not, whether a passenger or a driver) Start with the most recent

| Date of Accident | Type | Speed | Spine Checked | Care Received and by Whom |
|---|---|---|---|---|
| *EX: 1998* | *Rear Ended* | *30* | *No Spinal Check* | *Took pain killers for 2 weeks* |
| • _____ | _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ | _____ |

1. When was you most recent stress/ strain/ fall at work or home, or while participating in sports/ recreational activities?

*Please try to list whatever you can remember*

| | | | |
|---|---|---|---|
| *EX: 2007* | *Fell at home* | *No spinal check* | *Went to physical therapy and took pain killers* |
| • _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ |
| • _____ | _____ | _____ | _____ |

2. Are there any other injuries to your spine, minor or major, that your doctor should know about?

_____

_____

_____

## YOUR GOALS (Please mark all of your interests)

☐Chiropractic ☐Scoliosis Reduction ☐Customized Detox ☐Nutrition/ Weight Loss ☐Wellness

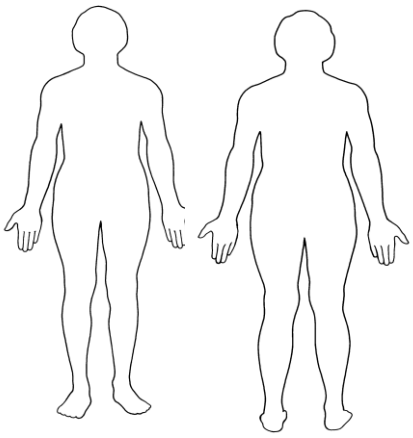
## HISTORY OF COMPLAINT

Subluxation can cause any problems, can you please identify the primary condition that brought you to this office:

**Primary Chief Complaint: _____**
Circle the severity: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain**

**Second Chief Complaint: _____**
Circle the Severity: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**

**Third Chief Complaint: _____**
Circle the Severity: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain**



*** PLEASE MARK the areas on the diagram with the following ***
Letters to describe symptoms
**R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness

1. Subluxations can effect nerves for long or short periods of time, when did your problem start? _____
2. Subluxations can cause irritation to different fibers within nerves. Circle all that would describe your problem.
   **Sharp Dull Aching Burning Stabbing Numbing Throbbing Radiating Tingling**
3. Subluxations can put pressure on the spinal cord. When do you feel your discomfort? **Constant or Occasionally**
4. Subluxations can effect the spine to make problems worse in the AM or PM. Which is worse for you? **AM or PM**
5. Subluxations can be aggravated by different movements/ postures, what makes your discomfort worse? _____
   _____
6. Subluxations can occur for long periods of time. Have you suffered with this problem in the past? **Yes or No**
   If yes, how many times? _____ When was the last episode? _____ What did you do? _____
7. Subluxations can cause nerve pressure; does it radiate into any extremity or stay in one area and where? _____
8. Have you had previous Chiropractic care? Yes or No Name of Chiropractor: _____
   How long were you under care? _____ How long ago? _____ Results? _____
9. Is your problem the result of any type of accident? **Yes or No**
   If yes identify type: ☐Auto ☐Work ☐Home ☐Other: _____
   Date of Accident: _____/_____/_____ Approximately what time of the day? _____ am _____ pm
   Have you reported this accident to anyone? ☐**Yes** ☐**No** if yes to whom? _____-

## SOCIAL HISTORY

1. Smoking: ☐Cigars ☐Pipe ☐Cigarettes _____ ☐Daily ☐Weekends ☐Occasionally ☐Never
2. Alcoholic Beverages: _____ ☐Daily ☐Weekends ☐Occasionally ☐Never
3. Recreational Drug Use: _____ ☐Daily ☐Weekends ☐Occasionally ☐Never
4. Hobbies – Recreational Activities – Exercise Routine: How doe your present problem affect the following?

| IDENTIFY TYPE: (golfing, swimming, running) | Effect: | | | |
|---|---|---|---|---|
| _____ | ☐No Effect | ☐Painful (can do) | ☐Painful (Limits) | ☐Unable to perform |
| _____ | ☐No Effect | ☐Painful (can do) | ☐Painful (Limits) | ☐Unable to perform |

## FAMILY HISTORY

Does anyone in your family suffer with the same condition? ☐Yes ☐No Who: _____

Any other hereditary conditions the doctor should be aware of? ☐Yes ☐No _____

Mother's History: ☐High Blood pressure ☐Diabetes ☐Cancer ☐Heart Disorders ☐Other _____

Father's History: ☐High Blood pressure ☐Diabetes ☐Cancer ☐Heart Disorders ☐Other _____

## WORK ACTIVITIES

1. Hours worked per day: _____ Days per week: _____ Does your job require lifting? ☐Yes ☐No
   If yes, what is the maximum required? ☐Min (<5lbs) ☐Light (5-20lbs) ☐Med (20-50lbs) ☐Heavy (>50lbs)
   Lifting frequency: ☐Constant (66-100% of Day) ☐Frequent (33-65 % of Day) ☐Occasional (0-32% of day)
   Lifting Postures: ☐Knee ☐Torso ☐Arm ☐Shoulder ☐Off posture
   Standing: _____ hrs/day Sitting: _____ Hrs/day Pushing: _____ hrs/day Twisting: _____hrs/day
   Pulling: _____ hrs/day Kneeling: _____ Hrs/day Reaching: _____ hrs/day Walking: _____hrs/day
2. Repetitive Activities:
   Computer: _____ hrs/day Grasping: _____ Hrs/day Hand tools: _____ hrs/day Machinery: _____hrs/day
   Assembly: _____ hrs/day Phone: _____ Hrs/day Other: _____hrs/day
3. Impact of current condition on work capacity: ☐No effect ☐Painful ☐Limits ☐Unable to work

## ACTIVITY OF DAILY LIVING

**Circle all activities that are more difficult to perform due to your condition:**

| | | | | |
|---|---|---|---|---|
| Carrying groceries | Computer use | Dressing | Standing | Dishes Other _____ |
| Sit to stand | Household Chores | Shaving | Yard work | Laundry Other _____ |
| Climbing Stairs | Lifting Children | Sexual Activities | Walking | Garbage |
| Pet care | Reading/ Concentration | Sleep | Washing/ bathing | Lifting groceries |
| Driving | Bathing | Sitting | Sweeping | Driving |

## PERSONAL HISTORY

| | | | |
|---|---|---|---|
| ___ Fractured Bones | ___ Sinus problems | ___ Fainting | ___ Varicose veins |
| ___ Auto Accidents | ___ Eating disorders | ___ Loss of Balance | ___ Liver trouble |
| ___ 0-1 year ago | ___ Trouble sleeping | ___ Blurred Vision | ___ Gall Bladder trouble |
| ___ 2-3 years ago | ___Trouble concentrating | ___ Double vision | ___ Digestive problems |
| ___ 4 years ago | ___ Learning Disability | ___Upper back Pain | ___ Heartburn |
| ___ Other Accidents/Falls | ___Mood Changes | ___Mid Back pain | ___ Ulcers |
| ___ Back Curvatures | ___Headaches | ___ Lower Back Pain | ___ Diarrhea/ Constipation |
| ___ Arthritis | ___ Pain/Stiff neck | ___ Numbness | ___ Colon Trouble |
| ___ Diabetes | ___Tingling | ___ Hemorrhoids | ___ Change in weight |
| ___ Swollen Painful Joints | ___ Pain with cough/sneeze | ___Prostate Problems | ___ Fatigue |
| ___ Epilepsy | ___ Jaw Pain TMJ | ___ Hip Pain | ___ Impotence |
| ___ Skin Problems | ___ Shoulders tired | ___ Foot trouble | ___ Kidney Trouble |
| ____ Cancer | ___ Difficulty Exercise | ___ Chest Pain | ___ Menstrual Problems |
| ___Frequesnt Colds | ___ Asthma | ___ Menopausal Problems | |
| ___Depressed | ___ Lung Problems | ___ Pregnant | ___ Cold feet/ hands |
| ___ Irritable | ___ Shoulder pain R L | ___ Difficulty Breathing | ___Bed Wetting |
| ___ Anemia | ___ Dizziness | ___ Heat problems | ___Ear infections |
| ___ Tremors | ___ Ringing ears R L | ___ Stroke | ___ AIDS/HIV |
| ___ Allergies | ___ Hearing Loss | ___ High Blood pressure | ___Disc Problems |

## FEMALES ONLY

1st day of your last menstrual cycle: _____ Are you Pregnant? ☐Yes ☐No Due Date: _____

Number of pregnancies: _____ Number of Children: _____ Type of birth: ☐Natural ☐Cesarean Section

## MEDICAL TREATMENT

Are you under care with a medical doctor for this condition? ☐Yes ☐No Who? _____

Current medication taking: _____ Other over the counter medication: _____

Vitamins/ Herbs: _____ Allergies: _____

I certify that the information is complete and accurate to the best of my knowledge. I agree to notify this office immediately whenever I have changes in my health condition or health plan converge in the future.

## INITIAL NUTRITIONAL PROFILE

Have you been tested for High Triglycerides or High Cholesterol? ☐ Yes ☐ No Values: _____

Have you tested with High Blood Pressure? ☐ Yes ☐ No Values: _____

Are you Diabetic? ☐ Yes ☐ No Have you been diagnosed as pre-diabetic or with metabolic syndrome? ☐ Yes ☐ No

Do you have breakfast Daily? ☐ Yes ☐ No How many days do you skip a meal? 0 1 2 3 4 5 6 7

How many fast food, refined foods or pre-pared meals do you eat per week? 0 1 2 3 4 5 6 7

How many servings of fruit do you have on a given day? 0 1-2 3-4 5-6 7+

How many servings of vegetable do you have on a given day? 0 1-2 3-4 5-6 7+

Do you regularly drink 1 or more of the following? Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you are taking: _____

## INITAIL FITNESS PROFILE

How many times per week do you exercise? _____ **Cardiovascular**: _____hrs____days/wk **Weight** ____hrs___days/wk

Do you do low impact exercise? (Yoga, Tai Chi, Qi Chng) ☐ Yes ☐ No

What is your target weight? _____ What is your current weight? _____ Height: _____

How willing are you to change any of these things to reach your health goals? (scale 1-10) _____

## INITAIL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? ☐ Yes ☐ No

Have you ever noticed mold growing in your home or your place of work? ☐ Yes ☐ No

Does your home, work, school or car have damp or mildew smell? ☐ Yes ☐ No

Have you received full standard profile of vaccinations? ☐ Yes ☐ No

Do you receive yearly Flu shots? ☐ Yes ☐ No

Have any member of your family been diagnosed with Fibromyalgia, Chronic Fatigue syndrome or chemical sensitivities? ☐ Yes ☐ No

Do you have symptoms of hormonal system imbalance? (Thyroid, reproductive or adrenal) ☐ Yes ☐ No

## INITIAL STRESS PROFILE

Do you get an average of 8 hours sleep per night? ☐ Yes ☐ No

Do you average less than 7 hours sleep per night? ☐ Yes ☐ No

Do you take pills to get to sleep or relax ☐ Yes ☐ No

Do you often feel short on time and procrastinate on projects? ☐ Yes ☐ No

Do you experience feelings of anxiety about completing tasks? ☐ Yes ☐ No

Do you feel like you don't give enough time to important area of your life? (family, personal growth) ☐ Yes ☐ No

Do you rely more on your memory than a planner and action list to get things done? ☐ Yes ☐ No

Do you take time to pray, meditate, on a regular basis? ☐ Yes ☐ No

## EXAMINERS USE ONLY

## INSURANCE ASSIGNMENT, RECORDS RELEASE AND INFORMED CONSENT

Please Provide A Picture ID and Your Health Insurance Card To The Front Desk

Insurance Company: _____ Policy #: _____ Group #: _____

Name of Insured: _____ SSN #: _____ DOB: _____

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

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Clermont Chiropractic Life Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

**REGARDING:** X-rays/Imaging Studies

**FEMALES ONLY** → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

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

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent for Clermont Chiropractic Life Center (CCLC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. CCLC reserves the right to revise its Notice of Privacy Practices. I have the right to request that CCLC restrict how it uses or discloses my PHI to carry out TPO. With this consent, CCLC may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CCLC may decline to provide treatment to me.

☐ I authorize and direct Clermont Chiropractic Life Center to **Release** copies of my medical records, x-rays, exam results and any other protected health information:

☐ I authorize and direct Clermont Chiropractic Life Center to **Request** copies of my medical records, x-rays, exam results and any other protected health information :

*This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. Any third party that receives protected health information is prohibited from further disclosing any information contained in the medical records without the consent of the patient or the patient's legal guardian.*

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I herby authorize the doctor to examine and treat my conditions he deems appropriate through the use of Chiropractic health care, and I give authority for these procedures to be preformed. It is understood and agreed the amount paid the doctor for radiographs is for examination only and the radiographs will remain the property of the office. The patient also agrees the he/she is responsible for all bills incurred at the office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medically diagnosis.

Patient's Name: _____Signature:_____ Date: _____