MORNINGSTAR CHIROPRACTIC
SPINAL CORRECTION CENTER

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. Our approach is very unique and advanced from other rehabilitative 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

_____

Today's Date

PATIENT APPLICATION INFORMATION

Date_____

Name_____ Age _____ Gender: M F

Home Address _____ Home Phone ( ) _____

City, State, Zip _____ Work Phone ( ) _____

Email Address _____ Cell Phone ( ) _____

Birth Date _____ / _____ / _____ Social Security Number _____ - _____ - _____ Marital status: S M D W

Names of children and 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—Main complaint _____

Is this purpose related to an auto accident / work injury? □ Yes □ No If yes, please see the front desk to get an additional form!

When did this condition begin? _____ /_____ /_____ Did it begin: □ Gradually □ Suddenly □ Progressively over time

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? □ Yes □ No If yes, describe: _____

Type of Pain: □ Sharp □ Dull □ Ache □ Burn □ Throb □ Spasm □ Numb □ Tingling □ Shooting

Does the pain radiate into your ___ Arm ___ Leg ___ does not radiate Is this condition getting worse? □ Yes □ No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint interfere with: ___Work ___Sleep ___Hobbies ___Daily routine Explain: _____

Have you experienced this condition before? □ Yes □ No If yes, 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 If yes, who? _____ When?_____

Reason for visits:_____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? □ Yes □ No

Do you understand how 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 bending forward and progressively 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 felt like you carry your head forward, noticed a rounding of your shoulders or developing a "hump" at the base of your neck? ____ Yes _____ No

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 _____
Do you smoke? □ Yes □ No If yes, how much? _____
Do you drink alcohol? □ Yes □ No If yes, how often per week? _____
Do you drink coffee? □ Yes □ No If yes, how many cups per day? _____
Do you take any supplements? □ Yes □ No What kinds? _____

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When those 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 affects on your overall health.

HEALTH CONDITIONS

Please check all health conditions you are experiencing now or in the past.

CERVICAL SPINE (NECK)

Postural distortions in your neck will weaken the nerves into your arms, hands and head. Do you experience…?

- □ Neck pain
- □ Headaches
- □ Pain into your shoulders/arms/hands
- □ Numbness/tingling in arms/hands
- □ Dizziness
- □ Coldness in hands
- □ Sinusitis
- □ Allergies/Hay fever
- □ Recurrent colds/Flu
- □ Low energy/Fatigue
- □ TMJ/Pain/Clicking
- □ Hearing disturbances
- □ Thyroid conditions
- □ Visual disturbances
- □ Weakness in grip

THORACIC SPINE (UPPER BACK)

Postural distortions in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience …?

- □ Upper back pain
- □ Heart Palpitations
- □ Heart Murmurs
- □ Tachycardia
- □ Heart Attacks/Angina
- □ Recurring Lung Infections/Bronchitis
- □ Asthma/Wheezing
- □ Shortness of Breath
- □ Thyroid conditions
- □ Pain on Deep Inspiration/Expiration

THORACIC SPINE (MID BACK)

Postural distortions in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- □ Mid Back Pain
- □ Pain in Ribs/Chest
- □ Indigestion/Heartburn
- □ Reflux
- □ Nausea
- □ Ulcers/Gastritis
- □ Hypoglycemia
- □ Tired/irritable after eating or when you haven't eaten for a while

LUMBAR SPINE (LOW BACK)

Postural distortions in the low back will weaken the nerves in your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- □ Low back pain
- □ Pain in hips/legs/feet
- □ Numbness/tingling in legs/feet
- □ Coldness in legs/feet
- □ Constipation/Diarrhea
- □ Weakness/injuries in hips/knees/ankles
- □ Recurrent bladder infections
- □ Frequent/difficulty urinating
- □ Sexual dysfunction

Please list any health condition not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

FAMILY HEALTH HISTORY

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

(Please indicate "S" for Self, "F" for family, or "B" for both, if applicable)

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia / Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox / Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago
____ Other:			

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both doctor and patient to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: an adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A sate of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it; nor do we offer advice regarding treatment prescribed by others. Therefore, you understand that seeking advice from another type of health care provider should not interfere with the vertebral subluxation corrective care provided by this office.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation!

CONSENT TO CARE

I do hereby authorize the doctors of Morningstar Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the primary doctor of chiropractic. Including those working at the primary clinic or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function through the reduction and/or removal of the subluxation complex.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from the programs offered, 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 for all services rendered.

I,_____ have read and fully understand the above statements.
(**PRINT NAME)**

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

X_____ X_____
(**SIGNATURE)** (**DATE)**

PREGNANCY RELEASE

This is to certify, to the best of my knowledge, that I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been evaluation. I have been advised that x-ray can be hazardous to an unborn child.

X_____ X_____
(**SIGNATURE)** (**DATE OF LAST MENSTRUAL CYCLE)**

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X_____ X_____
(**SIGNATURE)** (**DATE)**

INSURANCE INFORMATION

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from Morningstar Chiropractic Spinal Correction Center is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, your full balance will be automatically be transferred to your credit card.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

DECLARATION

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.

Signature _____ Date: _____

(Signature should be of patient, parent or legal guardian.)

Relationship to Insured if other than patient _____

Primary Insurance Company _____Policy # _____

If we did not take a copy of the insurance card, then please provide the address and phone #.

_____

Insured's Name _____ Insured's Date of Birth _____

Secondary Insurance Company _____Policy # _____

If we did not take a copy of the insurance card, then please provide the address and phone #.

_____

Insured's Name _____ Insured's Date of Birth _____