



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...?

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Coldness in hands | <input type="checkbox"/> TMJ/Pain/Clicking |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Hearing disturbances |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Thyroid conditions |
| <input type="checkbox"/> Numbness/tingling in arms/hands | <input type="checkbox"/> Recurrent colds/Flu | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low energy/Fatigue | <input type="checkbox"/> 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 ...?

- | | |
|---|---|
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Recurring Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Asthma/Wheezing |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Thyroid conditions |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> 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...?

- | | |
|--|---|
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Pain in 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 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...?

- | | |
|---|---|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Weakness/injuries in hips/knees/ankles |
| <input type="checkbox"/> Pain in hips/legs/feet | <input type="checkbox"/> Recurrent bladder infections |
| <input type="checkbox"/> Numbness/tingling in legs/feet | <input type="checkbox"/> Frequent/difficulty urinating |
| <input type="checkbox"/> Coldness in legs/feet | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Constipation/Diarrhea | |

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)

<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"/> Paralysis	<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 / Bronchitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox / Shingles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Blood Sugar Problems	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Lumbago
<input type="checkbox"/> 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 state 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 _____
(SIGNATURE)

X _____
(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 _____
(SIGNATURE)

X _____
(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 _____
(SIGNATURE)

X _____
(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 #.

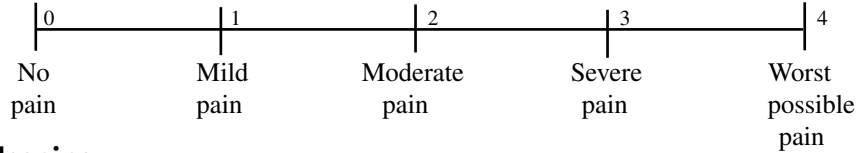
Insured's Name _____ Insured's Date of Birth _____

Functional Rating Index

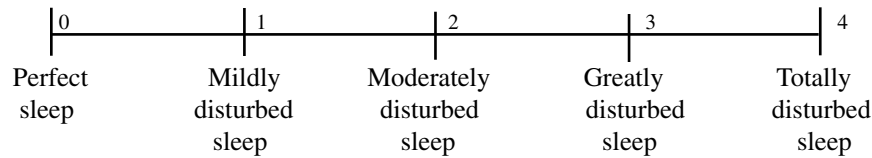
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

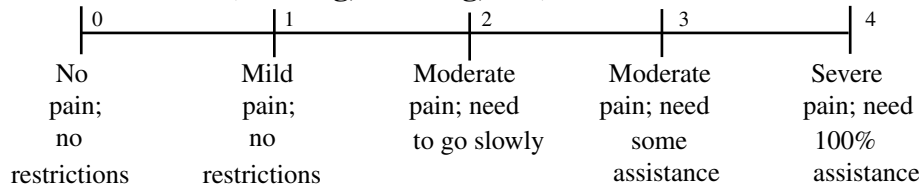
1. Pain Intensity



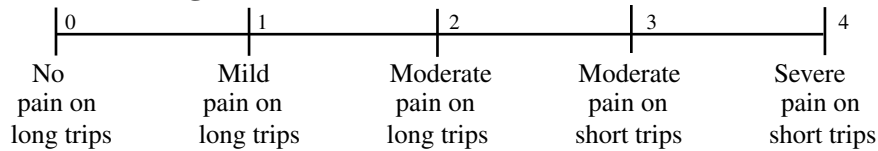
2. Sleeping



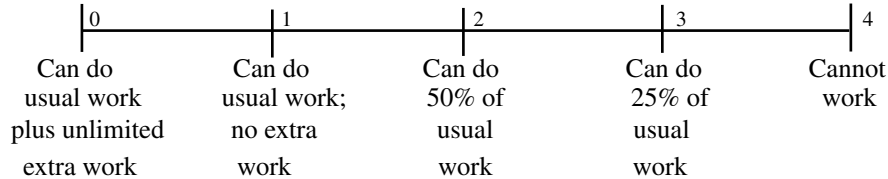
3. Personal Care (washing, dressing, etc.)



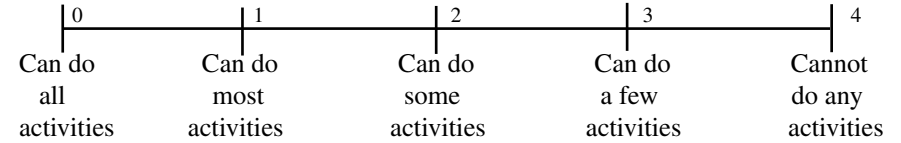
4. Travel (driving, etc.)



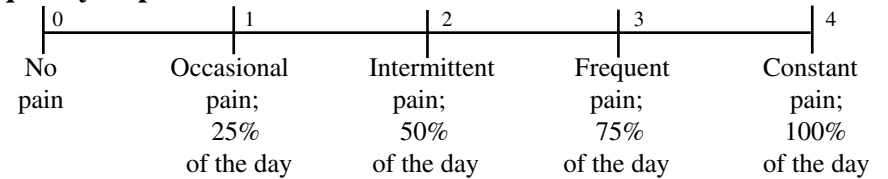
5. Work



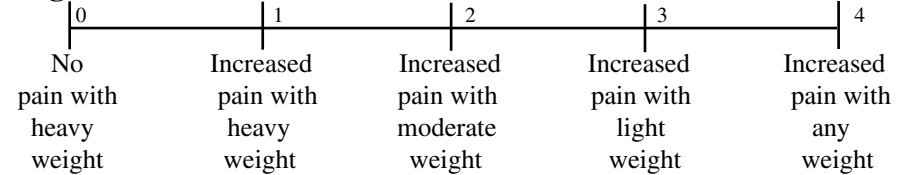
6. Recreation



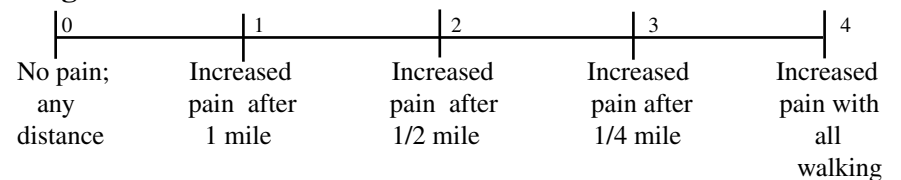
7. Frequency of pain



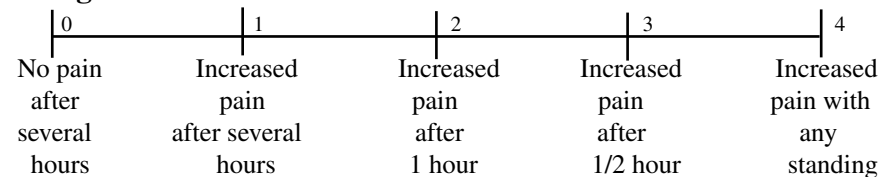
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, and law enforcement activities (i.e. child abuse, neglect, domestic violence, adult abuse, lawsuits, injury disability). Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. Our practice may disclose your protected health information (PHI) to public health authorities by law for the purpose of:

- Reporting child/adult abuse or neglect.
- Preventing or controlling disease injury, or disability.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement in response to a warrant, summons, court order, subpoena or similar legal process.
- Investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs.
- To identify a deceased individual or to identify the cause of death.
- For payment/billing purposes.

This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Front Desk Manager.

Name Sheila Hartnett Phone 618-288-8090

The effective date of this Notice of Information Practices is 8/17/2015

Thank you.