

# GREEN CHIROPRACTIC

*Alignment matters*

BETTER SPINE, BETTER LIFE

## Patient Application

WELCOME, and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed.

**Because of this specialized approach, we may not accept you as a patient until we perform the necessary tests that will give us insight into the cause of your condition, allowing us to develop an optimal rehab program for you, and are confident we can help you. If we accept you as a patient, we will make your health a priority and expect you will as well.**

### Patient Information

Full Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Marital Status: S M D W Number of children: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

List two persons way may contact in case of an emergency

Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

### Health & Lifestyle

Do you smoke?  No Packs per day: \_\_\_\_\_ Years: \_\_\_\_\_

Do you drink alcohol?  No  Social  Light  Moderate  Heavy

Do you drink coffee?  No Cups per day: \_\_\_\_\_

Do you exercise?  No  Occasionally  Regularly Times per week: \_\_\_\_\_

If yes, what type of exercise? \_\_\_\_\_

Please list hobbies/leisure activities: \_\_\_\_\_

Work is mostly:  Office/Clerical  Homemaker  Light Labor  Moderate Labor  Heavy Labor

Do you take any supplements (i.e. vitamins, minerals, herbs)?  None  Yes, please list: \_\_\_\_\_

## Purpose for this Visit - **MAIN** Reason - **ONE** area only

**Main** reason for this visit (describe): \_\_\_\_\_

When did these symptoms begin? \_\_\_\_\_

Is this related to an accident or specific injury?  No  Yes

If yes, explain: \_\_\_\_\_

Are the symptoms:  Constant  Intermittent  Activity-related

Are the symptoms:  Improving  Getting Worse  Remaining the same

What aggravates your symptoms? \_\_\_\_\_

Is there anything that relieves the symptoms?  No  Yes: \_\_\_\_\_

Have you experienced these symptoms before?  No  Yes, when? \_\_\_\_\_

Have you already been treated for this?  No  Yes, who did you see? \_\_\_\_\_

What treatment was performed, and how did you respond? \_\_\_\_\_

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

## Purpose for this Visit - **SECONDARY** Reason - any other areas

**Other** reason for this visit (describe): \_\_\_\_\_

When did these symptoms begin? \_\_\_\_\_

Is this related to an accident or specific injury?  No  Yes

If yes, explain: \_\_\_\_\_

Are the symptoms:  Constant  Intermittent  Activity-related

Are the symptoms:  Improving  Getting Worse  Remaining the same

What aggravates your symptoms? \_\_\_\_\_

Is there anything that relieves the symptoms?  No  Yes: \_\_\_\_\_

Have you experienced these symptoms before?  No  Yes, when? \_\_\_\_\_

Have you already been treated for this?  No  Yes, who did you see? \_\_\_\_\_

What treatment was performed, and how did you respond? \_\_\_\_\_

What is your pain **RIGHT NOW**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your **TYPICAL** or **AVERAGE** pain? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

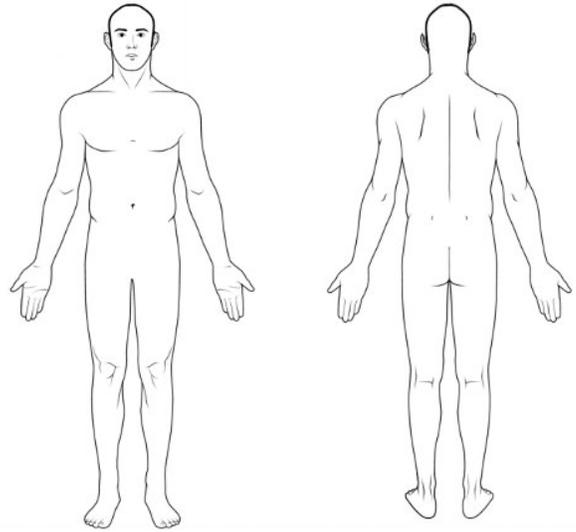
What is your pain level **AT ITS BEST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

What is your pain level **AT ITS WORST**? None 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Severe

# Symptoms Chart

Please **shade** the areas of symptoms and **label** the diagram using the following abbreviations.

- A** Ache
- B** Burning
- S** Sharp / stabbing
- N** Numbness
- T** Tingling
- O** Other



## Activities of Daily Life

Please identify how your current condition(s) is affecting your ability to carry out routine activities.

**Choose one for each of the activities below:**

- Activity has no effect,
- You can do activity, but it is painful,
- You are limited in the activity, and it is painful,
- You are unable to perform the activity.

ACTIVITIES:

EFFECTS:

Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Exercise	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Going Up & Down Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (Can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

# Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL areas of the spine. These distortions are reflected in abnormal posture. Misalignment of the individual vertebrae or distortion of the normal spinal curves may result in many health conditions. Please answer the following questions accurately so we may determine the full extent of your condition.

**Please indicate next to all conditions you've experienced: (N) = Now (P) = Past (B) = Both**

## CERVICAL SPINE (NECK)

None

- |                                     |                          |                         |
|-------------------------------------|--------------------------|-------------------------|
| ___ Neck pain                       | ___ Headaches            | ___ Thyroid conditions  |
| ___ Pain in shoulders/arms/hands    | ___ Dizziness            | ___ Low energy/fatigue  |
| ___ Numbness/tingling in arms/hands | ___ Visual disturbances  | ___ Recurrent colds/Flu |
| ___ Coldness in hands               | ___ Hearing disturbances | ___ Sinus infections    |
| ___ Weakness in grip                | ___ Jaw pain/clicking    | ___ Allergies/Hay fever |

Please explain: \_\_\_\_\_

## THORACIC SPINE (UPPER BACK)

None

- |   |  |                                   |
|---|--|-----------------------------------|
| ___ Upper back pain                     | ___ Asthma/wheezing                      | ___ Heart palpitations            |
| ___ Pain on deep inspiration/expiration | ___ Recurrent lung infections/bronchitis | ___ Tachycardia (rapid heartbeat) |
| ___ Shortness of breath                 | ___ Heart attack/angina                  | ___ Heart murmurs                 |

## THORACIC SPINE (MID BACK)

None

- |                           |   |                          |
|---------------------------|---|--------------------------|
| ___ Mid back pain         | ___ Nausea/upset stomach  | ___ High/low blood sugar |
| ___ Pain in chest/ribs    | ___ Ulcers/gastritis  |                          |
| ___ Indigestion/heartburn | ___ Diabetes  |                          |
| ___ Reflux                | ___ Tired/irritable after eating or when not have eaten for a while |                          |

Please explain: \_\_\_\_\_

## LUMBAR SPINE (LOWER BACK)

None

- |                                    |                                |   |
|------------------------------------|--------------------------------|---|
| ___ Low back pain                  | ___ Weakness/injuries in       | ___ Frequent/difficulty in urinating      |
| ___ Pain in hips/legs/feet         | hips/kness/ankles              | ___ Recurrent bladder infections          |
| ___ Numbness/tingling in legs/feet | ___ Muscle cramps in legs/feet | ___ Sexual dysfunction                    |
| ___ Coldness in legs/feet          | ___ Constipation/diarrhea      | ___ Menstrual irregularities/<br>cramping |
|                                    | ___ Irritable bowel syndrome   |   |

Please explain: \_\_\_\_\_

# Other Health Information

Current primary care provider: \_\_\_\_\_

Do you have allergies?  No  Yes: \_\_\_\_\_

Do you take any over-the-counter medication?  No  Yes, list how much/often: \_\_\_\_\_

Do you take any prescription medication?  No  Yes, see below

Please list any prescription medications:

Medication	How much/often	Starting Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgeries (include type of surgery and date performed)  None

Surgery	Date
_____	_____
_____	_____
_____	_____

# Health History

Are you aware of any poor posture habits?  No  Yes

If yes, explain: \_\_\_\_\_

Do you have or have you had any of the following? Please check the boxes below for the conditions that apply.

- None
- Cancer
- Heart disease
- High blood pressure
- High cholesterol
- Circulatory problems
- Stroke
- Neurological problems
- Epilepsy/seizures
- ADHD/ADD
- Depression
- Migraine headaches
- Diabetes
- Low blood sugar levels
- Gallbladder problems
- Tonsillectomy
- Appendectomy
- Hernia
- Lung disease
- Liver disease
- Kidney disease
- Thyroid problems
- Fibromyalgia
- Eczema/psoriasis
- Shingles
- Lyme disease
- Autoimmune disorder
- Osteoporosis
- Arthritis
- Broken bones/fractures
- Scoliosis

Please explain: \_\_\_\_\_

Please list any health conditions not mentioned: \_\_\_\_\_

# Family Health History

Is there any history of spinal problems in your family?  No  Yes

If yes, explain: \_\_\_\_\_

Is there a family history of:  None

	Cancer	Heart Disease	Diabetes	Arthritis	Other
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

# Experience with Chiropractic

Have you seen a chiropractor before?  No  Yes Who? \_\_\_\_\_

For what? \_\_\_\_\_

How long were you treated? \_\_\_\_\_ Last treatment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

How did you respond? \_\_\_\_\_

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

Did he/she recommend a specific course of treatment?  No  Yes

Did he/she recommend a home health care program?  No  Yes

If yes, what? \_\_\_\_\_

# Pregnancy Release (Women Only)

Are you pregnant?  Yes  No

If no:

By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. The doctors at Green Chiropractic have my permission to perform an x-ray evaluation.

Date of last menstrual cycle: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_  
Date

# Green Chiropractic Financial Policies

Green Chiropractic will do everything we can to bring out the best in you and your health, but we wish to make it very clear that your health is your responsibility. Our financial options are listed below. Please select the appropriate one and sign your acknowledgement of our policy below.

## CASH

Payment is due at the time services are rendered. We accept cash, check, debit, Visa, Mastercard, Discover and AmEx cards.

## INSURANCE PLAN

Many insurance policies provide coverage for chiropractic care. Benefits will vary from policy to policy and cannot be guaranteed until an Explanation of Benefits (EOB) is received. Payment on your first visit is required to establish your account. We will contact your primary carrier to obtain benefits and process your claims. Any remaining balance is your responsibility.

## MEDICARE

Payment is due at the time services are rendered. Exams, x-rays and supplements are a non-covered service with Medicare. We will submit your charges to Medicare. We are considered non-assignment; therefore, any EOB's and/or payments made by Medicare will be sent directly to you.

## MEDICAID

For managed care plans, WellCare Health Plan and Nebraska Total Care are accepted. We are out of network with United Health Care, so Medicaid provided through United HealthCare will not cover our services. Visit limits and co-pays may apply.

## PERSONAL INJURY

Please provide Green Chiropractic with any accident reports and attorney information. We will send your claims to your auto insurance carrier if you have a MedPay policy. Any remaining balance is your responsibility.

## WORKER'S COMP

Prior approval is typically required before any services are rendered. Obtain and provide Green Chiropractic with the name of your employer's work comp insurance carrier and claim number.

I clearly understand that all insurance 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 strictly as a convenience to me. The chiropractic 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.

---

Patient's Signature

---

Date