ELITE CHIROPRACTIC & WELLNESS
PATIENT APPLICATION

Tell us About Yourself

_____
Name

_____
Address

_____
City State Zip

_____
Cell Phone

_____
E-mail (updates on office hours, events, education, etc.)

_____
Birthdate Age Gender

_____
Marital Status Spouse/Partner's Name

_____
Children Name's & Ages

_____
Occupation Employer's Name

_____
Emergency Contact Name Phone Number

_____
How did you hear about Elite Chiropractic & Wellness?

Chiropractic history

Have you ever visited a chiropractor? ☐ Yes ☐ No

What did you enjoy about your previous experience? _____

_____

_____

How can I help you?

What is your primary health concern? _____

_____

_____

On a scale of 1-10, how would you rate your symptoms at their worse?

(low) 1 2 3 4 5 6 7 8 9 10 (high)

How often do you experience symptoms?

Constant | Frequent | Intermittent | Occasional

How would you describe your symptoms?

Dull | Achy | Sharp | Stiffness | Tightness | Other

How long have you had this problem? How do you think it started?

_____

_____

On a scale of **1-10**, how much does this problem interfere with:

Work _____
Sleep _____
Exercise _____
Driving _____
Sitting _____
Walking _____
Standing _____
Focus _____
Mood _____
Hobbies _____
Other _____

What is your level of commitment to yourself and your health?

(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Traumas: Physical Injury History

Please all **injuries** (falls, broken bones, sprains, etc.) and approximate date of injury:

_____

_____

_____

_____

Surgeries _____

Auto accidents _____

Exercise Frequency: ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ Daily

Types of exercise:

_____

_____

How do you normally sleep? ☐ Back ☐ Stomach ☐ Side

Do you wake up ☐ Refreshed and ready ☐ Stiff and tired

List any problems with flexibility/mobility (ex. Bending over to tie shoes, etc.) _____

How many hours per day do you spend sitting? _____

Thoughts: Emotional Stresses

On a scale of **1-10**, please rate the following stresses in your life:

Home _____

Work _____

Life _____

Finances _____

Health _____

Family _____

Toxins: Chemicals & Diet

In an average week, how much do you consume of each:

Alcohol _____ (# of drinks/week)

Water _____ (# of ounces/day)

Candy/Cookies/etc. _____ (# of days/week)

Dairy _____ (# of days/week)

Gluten _____ (# of days/week)

Processed Foods _____ (# of days/week)

Artificial Sweeteners _____ (# of days/week)

Sugary drinks _____ (# of days/week)

Nicotine _____ (# of servings/day)

Recreational drugs _____ (# of servings/week)

Fruit _____ (# of servings/day)

Vegetables _____ (# of servings/day)

Please list an other drugs/vitamins/herbs/supplements that you are taking _____

_____

Family History

Does anyone in your family have a history of:

Heart Disease ☐ No ☐ Yes _____

Stroke ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____

Cancer ☐ No ☐ Yes _____

↑Blood Press. ☐ No ☐ Yes _____

↑ Cholesterol ☐ No ☐ Yes _____

Other _____

_____

_____

_____

Top 3 Health & Life Goals (Think BIG!)

1. _____

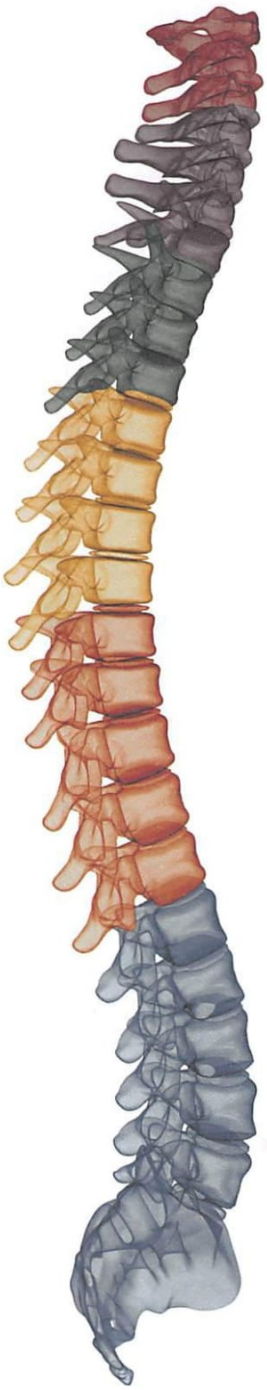
2. _____

3. _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name: _____ Date: / /

AUTHORIZATION FOR CARE

I hereby authorize the doctors and staff at Elite Chiropractic & Wellness to treat my condition as deemed appropriate. At Elite Chiropractic & Wellness, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor's/clinic will not be held responsible for any pre-existing medical condition. I certify that the above information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Elite Chiropractic & Wellness responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment I remarkable safe, you need to be informed about the protentional risks related to your care to allow you to be fully informed before consenting to treatment. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a results of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Signed:_____ **Date:**_____

PERSONAL INJURY CASES

I hereby authorize Elite Chiropractic & Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred to me.
I authorized the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based on in whole or in part upon the charges made for you services.
I understand that whatever amount you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.
I, the undersigned, do hereby appoint Elite Chiropractic & Wellness authority necessary to endorse and cash my checks, drafts, or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that are services rendered 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 me will be immediately due and payable. I will be responsible for any costs of collection, attorneys' fee or court costs required to collect my bill.

Signed:_____ **Date:**_____

CONSENT TO X-RAY

Patient consent to X-Ray
I authorize the performance of x-ray examination, which may incur an additional cost at Health Images. Elite Chiropractic & Wellness may consider imaging necessary or advisable in the course of my examination and treatment.

Signed:_____ **Date:**_____

X-Ray Consent for Women of Childbearing Age
This is to certify, to the best of my knowledge, I am not pregnant, and Elite Chiropractic & Wellness has my permission to refer me to receive diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed:_____ **Date:**_____

Doctor's signature:_____ **Date:**_____