APPLICATION FOR CARE AT FREEDOM CHIROPRACTIC HEALTH CENTER

Who may we thank for referring you to this office? _____ Today's Date:_____

PATIENT DEMOGRAPHICS

Name:_____ Birth Date:_____/_____/_____ Age:_____

Home Address:_____City_____State_____Zip_____

Home Phone: (_____)_____-_____ Email Address:_____

Mobile Phone: (_____)_____-_____ Occupation:_____ (Circle One) Full-time/ Part-time

Work Phone: (_____)_____-_____ Marital Status: S / M Sex: M / F Insurance: Y / N

Spouse's Name:_____

Number of Children and Ages: _____

Emergency Contact:_____ Contact Number: (_____)_____-_____

MEDICAL HISTORY

What Brought You Into the Office Today: (Circle One)	To Get Checked	Pain

IF YOU ANSWERED PAIN TO THE PREVIOUS QUESTION, PLEASE IDENTIFY THE CONDITIONS THAT BROUGHT YOU INTO OUR OFFICE:

Complaint:		On a Scale from 1-10, (**10** being the worst pain and **0** being no pain) **Please Rate Your Pain:**
Primary Complaint:		0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second Complaint:		0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third Complaint:		0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth Complaint:		0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did your pain begin?	**When is it at its worst?** AM Mid-Day PM Late Night
How long does it last? Constant	On and off during the day Comes and goes throughout the week
Is your pain injury/accident related? Y / N	**How did the injury/accident happen?**
Have you suffered with any of this or a similar problem in the past? Y / N	**How long ago?**
Has your condition ever been treated by anyone in the past? Y / N	**What type of Treatment?** / **Did you see results?** Y / N
What relieves your symptoms?	
What makes them feel worse?	
Have you been seen by a previous Chiropractor? Y / N	**If Yes, By whom?**
Is there any specific injury(s) to your spine (minor or major) **that the doctor should know about?**	

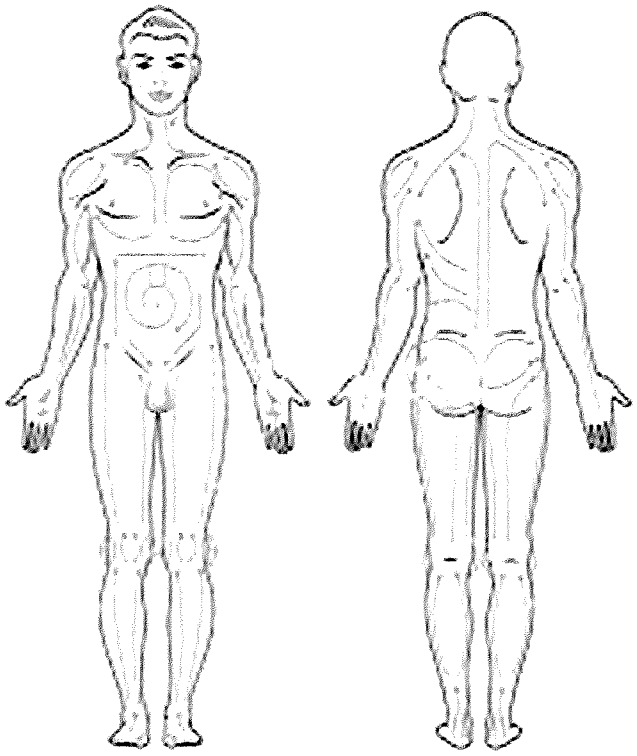
SOCIAL HISTORY			
Do You Smoke: Y / N	Daily	Weekends	Occasionally
Do You Drink Alcohol: Y / N	Daily	Weekends	Occasionally
Do You Use Recreational Drugs: Y / N	Daily	Weekends	Occasionally

FAMILY HISTORY	
Does anyone in your family suffer with the same condition? Y / N	**If Yes, Whom?**
Have they ever been treated for their condition? Y / N	**Any Hereditary conditions the doctor should know about?** Y / N

PLEASE MARK THE AREAS ON THE DIAGRAM WITH THE FOLLOWING LETTERS TO DESCRIBE YOUR SYMPTOMS:

N=NUMBNESS **S**=SHARP/STABBING **T**=TINGLING

R=RADIATING **B**=BURNING **D**=DULL **A**=ACHING



LIST ANY PRESCRIPTION & NON-PRESCRIPTION DRUGS YOU TAKE:

I hereby authorize payment to be made directly to Freedom Chiropractic Health Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payment, and further acknowledgement that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Freedom Chiropractic Health Center for any and all services I receive at this office.

_____ _____/_____/_____

Patient or Authorized Person's Signature Date Completed

_____ _____/_____/_____

Doctor's Signature Date Form Reviewed

DAILY ACTIVITIES: EFFECTS ON CURRENT CONDITIONS OF PERFORMANCE			
PLEASE CHECK THE BOX TO HELP IDENTIFY HOW YOUR CURRENT CONDITION IS AFFECTING YOUR ABILITY TO CARRY OUT THE FOLLOWING ACTIVITES:	**No Effect**	**Painful** (can do w/ limits)	**Unable to Perform**
Bending			
Concentrating			
Doing Computer Work			
Recreation Activities			
Sleeping			
Dressing			
Lifting			
Pushing			
Rolling Over			
Sitting			
Standing			
Driving			
Performing Sexual Activity			
Running			
Sitting to Standing			
Walking			

PLEASE IDENTIFY ALL PAST AND CURRENT CONDITIONS:

MARK: P FOR PAST C FOR CURRENT

___ Digestive Problems	___ Shoulder Pain	___Ulcers	___ Depression	___Arthritis	___ Jaw Pain/TMJ
___ Frequent Cold/Flu	___Menstrual Problems	___Hip Pain	___ Dislocations	___Chest Pain	___ Surgeries
___ Convulsions/Epilepsy	___Broken Bone	___Pregnant	___Mood Changes	___Fracture	___Hepatitis (A,B,C)
___Prostate Problems	___Mid Back Pain	___Asthma	___ Upper Back Pain	___Cancer	___Adult Disease
___ Double/Blurred Vision	___Eating Disorder	___ Neck Pain	___Bed Wetting	___Dizziness	___Serious Injuries
___ Colon Trouble	___Trouble Sleeping	___Tumors	___Liver Trouble	___Headache	___ Ringing in Ears
___ Heart Problems	___Heart Attack	___Tremors	___Swollen/Painful Joints	___Allergies	___ Diabetes
___Low Back Pain	___ Kidney Trouble	___ADD/ADHD	___Childhood Disease	___ Scoliosis	___Dizziness
___Menopausal Problems	___ Foot/Knee Problems	___Cerebral Vascular	___Impotence/ Sexual Dysf	___ Sinus Problems	___ High/Low Blood Pressure
___Gall Bladder Trouble	___ Numb/Tingling Legs, Feet, Toes	___ Numb/Tingling Arms, Hands, Fingers	___Other Serious Conditions		

Any Addition Comments About Daily Activities and/or Past or Current Conditions:

WE WANT TO HELP YOU ACHIEVE THE BEST VERSION OF YOURSELF!

(Please list some of your life goals and where you see yourself in 10 years)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Freedom Chiropractic Health Center Office Policies

As a potential new patient, we know it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read our "Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your application for care, please let our front desk know and a member of our staff will be happy to discuss them with you further.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patients care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

Patient Privacy - since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patient are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. **These consultations much be scheduled in advance.**

Your Care – when a patient seeks chiropractic health care and we agree to provide care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Freedom Chiropractic Health Center is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body innate wisdom. The doctors use 1.) Clear institute or 2.) A myriad of techniques to accomplish this goal, including but not limited to Chiropractic Biophysics, Pettibon, or Diversified. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

First Things Frist – prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health, and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. At your second appointment, all relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. This is the appointment that you will be receiving your first adjustment. Our gold standard for care is to ensure the reduction of subluxation while teaching patient what they need to do in addition to being adjusted to maintain their health for a lifetime.

Patient Report of Findings – to enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first appointment, you will be scheduled for a "Report of Findings". The information you receive at this appointment will be both informative and clinically relevant to your case, **therefore attendance is required for individuals who wish to become new patients** of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, **we strongly urge new patients to invite their spouse or significant other to attend**. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge that I have read and retained the practice's "Office Policies" document. A signed copy will be retained by the practice as evidence of my receiving and understanding this "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____/_____/_____

(Print) Patient's Name Date of Birth

_____ _____/_____/_____

Patient's Signature Todays Date

_____ _____/_____/_____

Witness Signature Todays Date

Freedom Chiropractic Health Center NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentially of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please sign, and return to our front desk receptionist where they can print a page for your records.

Permitted Disclosures:

1. Treatment purposes – discussion with other health care providers involved in your care
2. Inadvertent disclosures – open treating area means open discussions. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room
3. For payment purposes – to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes – to process a claim or aid in investigation
5. Emergency – in an event of a medical emergency we may notify a family member
6. For public health and safety – in order to p recent or lessen a serious or eminent threat to the health or safety or a person or general public
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
8. Decreased persons – discussion with coroners and medical examiners in the event of a patient's death
9. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
10. Change of ownership – in an event this practice is sold, the new owners would have access to your PHI

Your Rights:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain user and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice or your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

I have received a copy of Freedom Chiropractic Health Center's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Complaints:
If you wish to make a formal complaint about how we handle your health information, please call our office at (701) 356-3242 to make an appointment with our manager. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Ave. SW Room 509F HHH Building Washington, DC 20201

Informed Consent: 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 risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation or 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 Freedom Chiropractic Health 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 herby 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.

_____ _____/_____/_____ _____

Patient or Authorized person's Signature Date Witness Initials

REGARDING: X-RAYS/IMAGING STUDIES

FEMALES ONLY

Please read carefully, include the appropriate date, and 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 diagnostic x-ray examination the doctor has deemed necessary I my case

_____	_____/_____/_____	_____
Patient or Authorized person's Signature	Date	Witness Initials