

Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT COLUMBIA FAMILY CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: Single Married Insurance: Yes No Military Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is : 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 the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

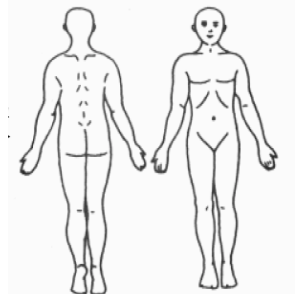
Name of Previous Chiropractor: _____ N/A

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes them feel worse? _____



LIST RESTRICTED ACTIVITY:

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

Is your problem the result of ANY type of accident? Yes, No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state **what** type of treatment: _____, and who provided it: _____ **How long ago?** _____ What were the results. Favorable Unfavorable → please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

List Prescription & Non-Prescription drugs you take: _____

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES	→		
SURGERIES	→		
CHILDHOOD DISEASES	→		
ADULT DISEASES	→		

SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes → How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs → Daily Weekends Occasionally Never
- 3. **Recreational Drug use:** Daily Weekends Occasionally Never
- 4. **Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following:

FAMILY HISTORY:

- 1. Does anyone in your family suffer with the same condition(s)? No Yes
If yes whom: grandmother grandfather mother father sister's brother's son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know
- 2. **Any other hereditary conditions the doctor should be aware of.** No Yes: _____

I hereby authorize payment to be made directly to Columbia Family Chiropractic, 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 payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Columbia Family Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

Date Completed

Doctor's Signature

Date Form Reviewed

Patient's Name: _____ HR#: _____ ___/___/___ JDD,DC 5/2011

PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING

<input type="checkbox"/> Headache	<input type="checkbox"/> Pregnant (Now)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Frequent Colds/Flu	<input type="checkbox"/> Fainting	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Jaw Pain/TMJ	<input type="checkbox"/> Convulsions/Epilepsy	<input type="checkbox"/> Vision Issues	<input type="checkbox"/> Impotence/Sexual Dysfunction	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Tremors	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Diarrhea/Constipation	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pain with a Cough/ Sneeze	<input type="checkbox"/> Depression	<input type="checkbox"/> Colon Trouble	<input type="checkbox"/> Liver Trouble
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Foot or Knee Problems	<input type="checkbox"/> Irritable	<input type="checkbox"/> Menopausal Problems	<input type="checkbox"/> Hepatitis (A, B, C)
<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Sinus/Drainage Problem	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Back Curvature	<input type="checkbox"/> Swollen/Painful Joints	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Asthma/Lung Problems
<input type="checkbox"/> Broken Bone	<input type="checkbox"/> Cerebral Vascular Problem	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Other (Describe)
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Tumor (location _____)	_____
<input type="checkbox"/> Numbness/Tingling (location _____)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Cancer (location _____)	_____	_____

AFFECTS OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely a part of your life:

	100% function	75% function	35% function	0% function
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<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
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<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
Sitting to Standing	<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
Standing	<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
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports/Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreational Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

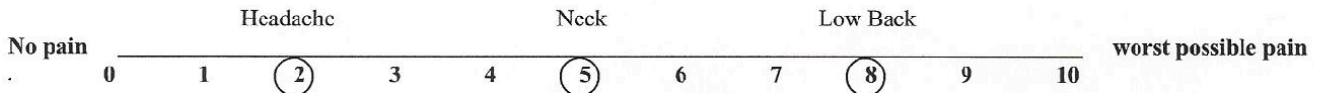
Date _____

Please read carefully:

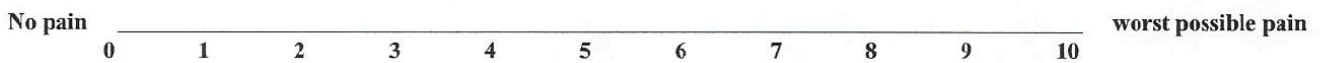
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

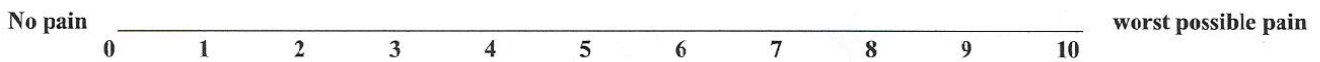
Example:



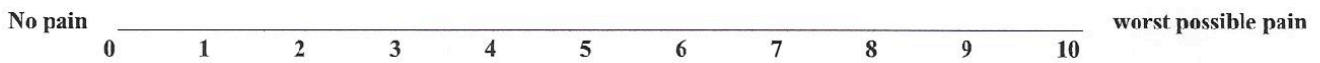
1 – What is your pain RIGHT NOW?



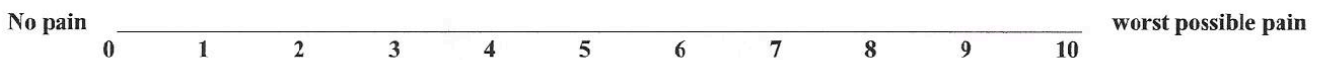
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Basic Lifestyle Assessment

Name: _____ Date: _____

Please answer yes or no to the following questions and then rate yourself 1-10.

1. **Stress Assessment:**

- Do I feel like I am always running out of time?
- Am I getting less than 7 hours of sleep per night?
- Am I focusing on the urgent instead of the important things in my life?
- Am I finding it hard to stick with a nutrition plan because I'm 'addicted' to certain foods?
- Do I often have self-defeating thoughts going through my head?
- Do you often feel short on time and procrastinate on projects?
- Do you experience feelings of anxiety about completing tasks?
- Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby?
- Do you rely more on your memory than a planner and action list to get things done?
- Do you take time to pray, meditate, or visualize on a regular basis?

Overall Rating 1 – 10 (1 = extreme stress, 10 = stress-free) _____

2. **Nutrition Assessment:**

- Do I drink sodas?
- Do I take quality supplements?
- Do I eat fast food on a weekly basis?
- Am I eating grains (pasta, rice, bread) on a regular basis?
- Do I do the cooking?
- Do I do the grocery shopping?

Overall Rating 1 – 10 (1 = poor nutrition, 10 = incredible diet) _____

3. **Fitness Assessment:**

- Am I my target weight?
- Do I feel sluggish or lethargic by the end of the day?
- Do I struggle with depression?
- Do I like the way I look in my underwear physically?
- Am I moving my body and getting my heart rate up at least 3 times per week?

Overall Rating 1 – 10 (1 = barely move, 10 = incredibly fit) _____

4. **Toxicity Assessment:**

- Am I on even one medication?
- Have I had flu shots or other vaccines in the past?
- Do I use conventional household cleaning products like laundry and dishwasher detergent?
- Do I have silver amalgam fillings in my teeth?
- Do I have any chemical sensitivities?
- Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)?
- Are you regularly exposed to cleaning products or industrial chemicals?
- Have you ever noticed mold growing in your home or your place of work?
- Does your home, work, school, or car have damp or mildew smell?

Overall Rating 1 – 10 (1 = toxic, 10 = not toxic) _____

COLUMBIA FAMILY CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality 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 statements below, 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. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

PERMITTED DISCLOSURES:

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas mean open discussion, 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 the event of a medical emergency we may notify a family member.
6. For public health and safety: In order to prevent or lessen a serious or eminent threat to the health or safety of 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. For military, national security, prisoner and government benefits purposes.
9. Deceased persons: For discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders: We may call your home and leave messages regarding a missed appointment or update you of changes in practice hours or upcoming events.
11. Change of ownership: In the 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 detailed privacy notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses 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 of 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). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you, however you will be responsible for this cost.

I understand my rights as well as the practice's 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. If you wish to make a formal complaint about how we handle your health information, please call Lindsay Stetson at (803) 788-8831 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days.

I am aware that a more comprehensive version of this notice is available to me and several copies 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.

Patient Name (print)

DOB

Patient Signature

Date

Witness Initial

COLUMBIA FAMILY CHIROPRACTIC'S OFFICE POLICY

Welcome to Columbia Family Chiropractic

As a potential new patient, we feel 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 Treatment**, please let our receptionist know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

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 patient 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 patients 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 must be scheduled in advance.

YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Columbia Family Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. 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 you overall health.

FIRST THINGS FIRST- 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. 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. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

PATIENT'S REPORT OF FINDINGS – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors 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 wished to become new patient 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 patients family understands the goals and objects 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 receiving a copy of the practices "Office Policies", the first page of which I have read and retained. This page is recognized by me as the signature page and 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.

Patient Name (print)

DOB

Patient Signature

Date

Witness Initial

INFORMED CONSENT

REGARDING: Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important for each patient to understand both the objective and the method that will be used to attain it. This will prevent 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 adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease, symptoms or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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 vertebral subluxation. However, if during the course of spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of the 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. OUR ONLY OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is the specific correction of vertebral subluxation.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Columbia Family Chiropractic have been explained to me to my satisfaction, and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to a full examination and treatment by any means, method, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

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 the diagnostic x-ray examination the doctor has deemed necessary in my case.

I hereby authorize payment to be made directly to Columbia Family Chiropractic, 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 payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Columbia Family Chiropractic for any and all services I receive at this office.

Print Name	DOB	
Patient or Authorized Person's Signature	Date	Witness Initial <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/>

FEMALES ONLY: Please read carefully, and check the boxes, include the appropriate date, then sign above 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 mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.