NEW PRACTICE MEMBER APPLICATION

Name_____**Date**____/____/____**Age**_____ **Male/Female**

Address_____**City**_____**State**_____**Zip**_____

Phone: Home_____ **Cell**_____ **Date of Birth**_____/_____/_____

Email Address_____

For confirming appointments, would you prefer? EMAIL or TEXT CELL PROVIDER IS _____

Occupation_____ **Employer's Name** _____

Single / Married / Divorced / Widowed **Spouse's Name**_____

Number of Children_____ **Names, Ages & Gender**_____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

	Health Concerns: List according to severity	Rate of Severity 1 = very mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent(I)
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____

IS YOUR PROBLEM THE RESULT OF ANY TYPE OF ACCIDENT? ☐ YES ☐ NO

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? ☐ YES ☐ NO

CHIROPRACTOR? _____ **MEDICAL DOCTOR?**_____**OTHER**_____

WHO AND WHEN?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

HEADACHES	*ADD/ADHD*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
MIGRAINES	*HEARING LOSS*	*HIGH BLOOD PRESSURE*	*DIZZINESS*	*EPILEPSY*
JAW/TMJ PAIN	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DIFFICULTY BREATHING*
EAR INFECTIONS	*RINGING IN THE EARS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NECK PAIN	*NUMBNESS IN ARMS/HANDS*	*NUMB. IN LEGS/FEET*	*FIBROMYALGIA*	*GERD/GASTRIC REFLUX*
SHOULDER PAIN	*DEPRESSION*	*LOW BLOOD PRESSURE*	*CHEST PAIN*	*BEDWETTING*
ARM PAIN	*MENSTRUAL DISORDER*	*STOMACH PROBLEMS*	*ARTHRITIS/JOINT PAIN*	*PROSTATE PROBLEMS*
UPPER BACK PAIN	*HEART PROBLEMS*	*TIGHT/SORE MUSCLES*	*NAUSEA*	*INFERTILITY*
MID BACK PAIN	*SPORTS INJURY*	*DOUBLE VISION*	*ALLERGIES*	*FIBROMYALGIA*
LOWER BACK PAIN	*LOSS OF ENERGY*	*ANXIETY*	*CONSTIPATION*	*TREMORS*
HIP/LEG PAIN	*ULCERS*	*SKIN PROBLEMS*	*DIARRHEA*	*DISC PROBLEMS*
KNEE PAIN	*BLADDER PROBLEMS*	*SCOLIOSIS*	*SEXUAL DYSFUNCTION*	*SLEEP PROBLEMS*
*OTHER:*_____	_____	_____	_____	_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS

DIABETES OSTEOARTHRITIS RHEUMATOID ARTHRITIS OTHER CONDITIONS/DISEASES:_____

LIST ALL SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO

IF YOU HAVE, DR. & DATE_____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? ☐ YES ☐ NO FRACTURED A BONE? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

_____

SOCIAL HISTORY

1.Smoking: **☐ Cigars ☐ Pipes ☐Cigarettes → How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never**

2.Exercise: How often? **☐ Daily ☐ 3-4 times/week ☐ Weekends ☐ Occasionally ☐ Never**

3.How do your present health concerns affect the following: HOBBIES – RECREATIONAL ACTIVITIES – EXERCISE

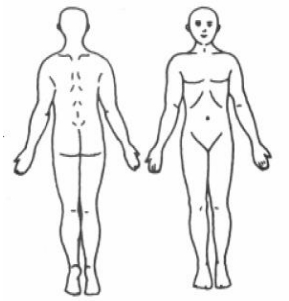
_____

_____

4.How would your life be different if you no longer had these health concerns?

_____

_____



PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.
AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.
THE FEE FOR COPYING YOUR X-RAYS IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.
DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.
PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS.**
THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF ATLAS CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.
BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____
PRINT YOUR NAME HERE **DATE**

_____ _____
SIGNATURE **YOUR AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT ATLAS CHIROPRACTIC.

_____ _____
SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Sex: ☐ M ☐ F

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MA 300 Size14x17

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17

Notes: _____
_____
_____
_____
_____
_____
_____

CA Initials:
_____

Practice Member Information (Must be Completed Before Services Can Be Rendered)

NAME: _____
FIRST MIDDLE LAST

PHONE: Home_____ Cell_____ Work_____

SOCIAL SECURITY NUMBER: _____ MARITIAL STATUS: _____

DATE OF BIRTH: _____

CONTACT IN CASE OF EMERGENCY: _____ Phone #: _____

NAME OF PRIMARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number _____

NAME OF SECONDARY INSURANCE CARRIER: _____

Name of Insured_____ Insured Date of Birth _____

Insured Social Security Number: _____

Insurance Policies and Fee Schedule

- **Consultation**- includes practice member history. This service is complimentary
- **Assessment (new or established practice member)-** includes one or more of the following: thermography, surface electromyography, range of motion, motion and/or static palpation, leg check $50-$75.
- **Chiropractic Adjustment-** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $30-$60.
- **X-rays-** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $40-75 per view.

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Blayne Baker DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment and that Atlas Chiropractic reserves the right to add a $25.00 service charge to my account for any returned check or charge back. I authorize this facility along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone.

Signed_____ **Date**_____

Terms of Acceptance

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health though chiropractic
G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

(Signature) **(Date)**

Please list any family members you wish to give consent to release any of your information to:

_____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURRING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT PRACTICE MEMBER'S NAME HERE

_____ _____

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW.

WRITTEN CONSENT FOR A CHILD

I AUTHORIZE DR. BLAYNE BAKER AND ANY AND ALL ATLAS CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY ATLAS CHIROPRACTIC.

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD: _____

_____ _____

GUARDIAN SIGNATURE **DATE**

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) **DATE**

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

_____ _____

DATE PLEASE PRINT YOUR NAME HERE

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
HEADACHES					
MIGRAINES					
SCOLIOSIS					
NECK PAIN					
TJM / JAW PAIN					
SINUS ISSUES					
ALLERGIES					
BACK PAIN					
DISC PROBLEMS					
DEPRESSION					
ARTHRITIS/ JOINT PAIN					
CARPAL TUNNEL SYNDROME					
EAR INFECTIONS					
HEARING LOSS					
DIZZINESS					
MENSTRUAL PROBLEMS					
LOSS OF ENERGY					
NERVOUSNESS					
BLURRED/ DOUBLE VISION					
ANXIETY					
ADD/ADHD					
HIP/LEG PAIN					
SHOULDER PAIN					
ARM PAIN					
THYROID PROBLEMS					
ASTHMA					
BREATHING PROBLEMS					
HIGH/ LOW BLOOD PRESSURE					
STOMACH PROBLEMS / GERD					
BED WETTING					
INFERTILITY					
SCIATICA					
FIBROMYALGIA					
POOR POSTURE					
SLEEP PROBLEMS					
STROKE					
CANCER					
HEART DISEASE					
DIABETES					
ALZHEIMERS					

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

NAME _____ **D.O.B.** _____ **Date** _____

Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please rate your pain right now, average pain, and pain at its best and worst.

EXAMPLE:

		headache		neck			low back				worst
no pain	_____										possible
0	1	2	3	4	5	6	7	8	9	10	pain

1. **What is your pain RIGHT NOW?**

											worst
no pain	_____										possible
0	1	2	3	4	5	6	7	8	9	10	pain

2. **What is your TYPICAL or AVERAGE pain?**

											worst
no pain	_____										possible
0	1	2	3	4	5	6	7	8	9	10	pain

3. **What is your pain level at its BEST (How close to "0" does your pain get at its best)?**

											worst
no pain	_____										possible
0	1	2	3	4	5	6	7	8	9	10	pain

4. **What is your pain level at its WORST (How close to "10" does your pain get at its worst)?**

											worst
no pain	_____										possible
0	1	2	3	4	5	6	7	8	9	10	pain

<u>Health Goals</u>

1.) _____

2.) _____

OATS INITIAL SCORE (Q1+Q2+Q3) ÷ Q3 x10 = ____
OATS EXPECTED OUT COME: OATS INITIAL SCORE ÷2 = ____
(Low Intensity < 50; High Intensity > 50)

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

Patient signature: _____ Today's Date: __/__/__