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

APPLICATION FOR CARE AT MAYNARD FAMILY CHIROPRACTIC MAXIMIZED LIVING HEALTH CENTE

Today's Date: ____________________

PATIENT DEMOGRAPHICS

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

Address: ____ City: ___________________________________ State: _____ Zip: ____________

Home Phone: ______________________________________ Mobile Phone: ____

Work Phone: ______________________________________ E-mail Address: ____

Employer: ____ Occupation: ____

Marital Status: M S D W Name of Spouse or Significant Other: ________________________________ # of Children: ________________

Name & Number of Emergency Contact: ____Relationship: ____________________________

Health Insurance: o Yes o None Insurance Company: ____

HISTORY OF COMPLAINT - PLEASE IDENTIFY THE CONDITION(S) THAT BROUGHT YOU INTO THIS OFFICE

Primary Complaint: ____

Secondary: ___________________________ Third: ______________________________ Fourth: ____________________________________

On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your above complaints by circling the number:

Primary complaint: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Secondary** 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 the problem(s) begin? _________________________________ When is the problem at its worst? o AM o PM

How long does it last? o It is Constant o It is Frequent o It is Intermittent o It is Occasional o It is Infrequent

What relieves your symptoms? _____________________________ What makes them feel worse? ___________________________________

Condition(s) ever been treated by anyone in the past? o No o Yes If yes, when? ___________ By whom? ___________________________

How long were you under care: ____________ What were the results? o Favorable o Unfavorable ______________________________

Name of Previous Chiropractor: ________________________________ o N/A

Is your problem the result of ANY type of accident? o Yes o No Date: ____ - ____ - _____

If yes identify type: o Auto o Work o Home o Other:_______________________________

Have you reported this accident to anyone? o No o Yes If yes to whom: _______________

When was your most recent auto accident? ____

Identify all sports or recreational activities you participate in:

____

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

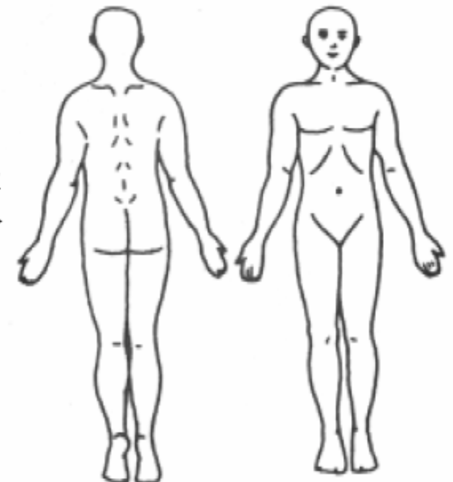
____

Any other serious conditions the doctor should know about? __________________________

____

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 **T**=Tingling



FAMILY AND PAST HISTORY

1. Any family history of disease or hereditary conditions? o No o Yes Please Explain:

____

2. Any past surgeries: ____

3. Please list any current medications you are taking: ____

PLEASE MARK “P” FOR PAST, “C” FOR CURRENT, AND “N” FOR NEVER FOR EACH OF THE FOLLOWING:

___Headache	___Pregnant (Now)	___Dizziness	___Prostate Problems	___Ulcers
___Neck Pain	___Frequent Colds/Flu	___Loss Of Balance	___Impotence/Sexual Dysfunctior	___Heartburn
___Jaw Pain/TMJ	___Convulsions/Epilepsy	___Fainting	___Digestive Problems	___Heart Problem
___Shoulder Pain	___Tremors	___Double Vision	___Colon Trouble	___High Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Mid Back Pain	___Pain with a Cough or Sneeze	___Ringing in the Ears	___Menopausal Problems	___Asthma
___Low Back Pain	___Foot or Knee Problems	___Hearing Loss	___Menstrual Problems	___Difficulty Breathing
___Hip Pain	___Sinus/Drainage Problem	___Depression	___PMS	___Lung Problem
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Bed Wetting	___Kidney Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Learning Disability	___Gall Bladder Trouble
___Broken Bone	___Cerebral Vascular Problem	___ADD/ADHD	___Eating Disorder	___Liver Trouble
___Dislocation	___Diabetes	___Allergies	___Trouble Sleeping	___Hepatitis (A, B, C)
___Numbness/Tingling in Arms, Hands, or Fingers		___Disability	___Tumor	___Rheumatoid
___Numbness/Tingling in Legs, Feet, or Toes		___Heart Attack	___Cancer	___Arthritis

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:

Bending	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Carrying	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Climbing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Concentrating	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Dancing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Doing Chores	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Doing Computer Work	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Dressing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Driving	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Gardening	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Lifting	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Performing Sexual Activity	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Playing Sports	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Pushing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Reading	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Recreating	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Rolling Over	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Running	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Shoveling	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Sitting	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Sitting to Standing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Sleeping	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Standing	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Walking	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Watching TV	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform
Working	o No Effect	o Painful (can do)	o Painful (limits)	o Unable to Perform

QUADRUPLE VISUAL ANALOGUE SCALE

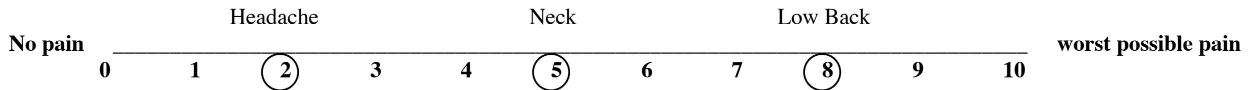
Patient Name ____ Date ___________________________

Please read carefully:

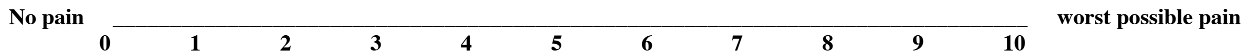
Instructions: Please circle the number that best describes the question being asked.

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.

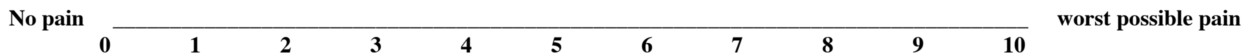
Example:



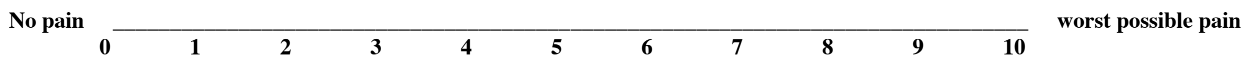
1 – What is your pain RIGHT NOW?



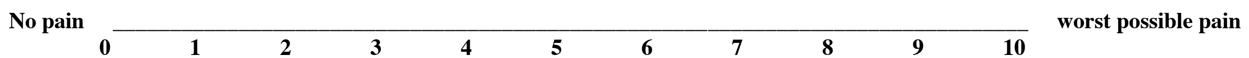
2 – What is your TYPICAL or AVERAGE pain?



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.

INFORMED CONSENT

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

Treatment Objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Maynard 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 Maynard 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 Maynard Family Chiropractic for any and all services I receive at this office.

____ ____/____/____ ☐ Witness Initial

Patient or Authorized Person's Signature Date

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.

o The first day of my last menstrual cycle was on ____/____/____
Date

o 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.

MAXIMIZED LIVING HEALTH CENTER'S 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.

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 DOB

____ _______________

Patient Signature Date

____ _______________

Witness Date

MAXIMIZED LIVING HEALTH CENTER'S OFFICE POLICY

Welcome to the Maximized Living Health Center!

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 front desk 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 first hand 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 **Maximized Living Health Center** 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 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 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 **DOB**

____ _______________

Patient Signature **Date**

____ _______________

Witness **Date**