



NEW PRACTICE MEMBER APPLICATION

Name: _____ Date of Birth: ____/____/____ Age: _____ Male Female

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

Cell phone: _____ Home phone: _____ Email Address: _____

Occupation: _____ Employer: _____ Social Security #: _____

Single Married Divorced Widowed Spouse's Name _____ # of Children: _____

Names, Ages, & gender: _____ Pregnant?: Yes No

Have you ever been in the military? Yes No Who may we thank for referring you? _____

↪ LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE BELOW ↩

Health Concern: (List according to Severity)	Severity (0-10) 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did this begin with an injury?	Are symptoms Constant (C) Intermittent (I)?
First: _____	_____	_____	_____	_____	_____
Second: _____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

HAVE YOU SEEN OTHER DOCTORS FOR THESE CONDITIONS? Yes No

CHIROPRACTOR MEDICAL DOCTOR Other: _____

WHO AND WHEN? _____ WHAT WERE THE RESULTS? FAVORABLE UNFAVORABLE (please explain)

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- ___ Headaches ___ Ear Infections ___ Sinus Issues ___ Kidney Problems ___ Sexual Dysfunction
- ___ Migraines ___ Hearing Loss ___ Frequent Colds ___ Bladder Problems ___ Sleep Problems
- ___ Jaw/TMJ Pain ___ Ringing in the Ears ___ Thyroid Issues ___ Menstrual Problems ___ Tight/Sore Muscles
- ___ Neck Pain ___ Dizziness ___ Asthma ___ Prostate Problems ___ Sports Injury
- ___ Shoulder Pain ___ Loss of Energy ___ Chest Pain ___ Infertility ___ Sciatica
- ___ Arm Pain ___ Nervousness ___ Heart Problems ___ Fibromyalgia ___ Arthritis/Joint Pain
- ___ Upper Back Pain ___ Double/Blurry Vision ___ Nausea ___ Epilepsy/Convulsions ___ GERD/Gastric Reflux
- ___ Mid Back Pain ___ Anxiety ___ Ulcers ___ Tremors ___ Numb/Tingling in Arms/Hands
- ___ Lower Back Pain ___ ADD/ADHD ___ Digestive Issues ___ Disc Problems ___ Numb/Tingling in Legs/Feet
- ___ Hip/Leg Pain ___ Loss of Balance ___ Diarrhea ___ Scoliosis ___ Stomach Problems
- ___ Knee Pain ___ Depression ___ Constipation ___ Poor Posture ___ High/Low Blood Pressure
- ___ Foot Pain ___ Allergies ___ Bed Wetting ___ Skin Problems ___ Difficulty Breathing

Other(s): _____

Doctor Signature: _____ Reviewed on: ____/____/____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Stroke ___ Cancer ___ Heart Attack ___ Spinal Surgery ___ Diabetes ___ Spinal Bone Fracture
 ___ Scoliosis ___ Arthritis ___ Seizures Please list any childhood Disorders: _____

PLEASE MARK the areas on the diagram with the following LETTER(S) 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? _____

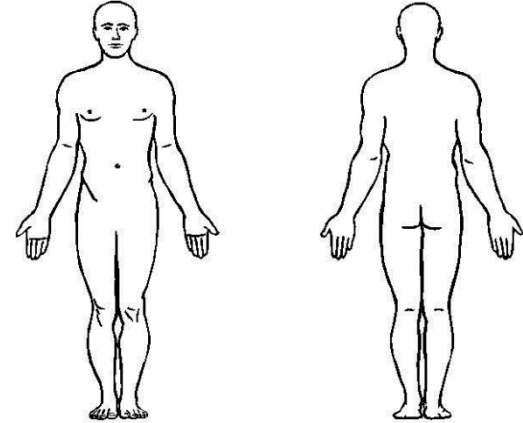
When is (are) the problem(s) at its worst? Circle: AM PM Mid-Day Late PM

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about: _____

List all over the counter & prescription medications you are on, & the reason for each: _____

Have you ever been in an auto accident? List all: _____



Have you ever been knocked unconscious? Yes: _____ No Fractured A Bone? Yes: _____
 No

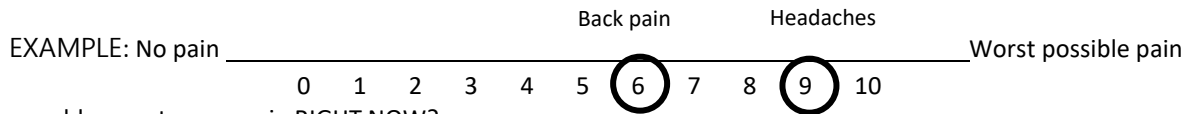
Other trauma(s): _____

Social History

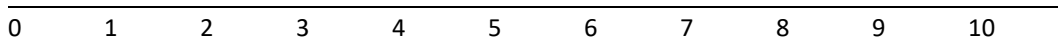
1. Smoking: cigars Cigarettes Pipe How Often? Daily Occasionally Never
2. Alcoholic Beverage: Daily Occasionally Never
3. Recreational Drug use: Daily Occasionally Never

QUADRUPLE VISUAL ANALOGUE SCALE

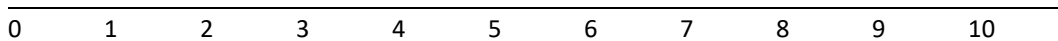
Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.



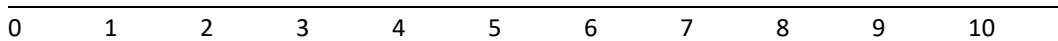
1. How would you rate your pain RIGHT NOW?



2. What is your typical or AVERAGE pain?

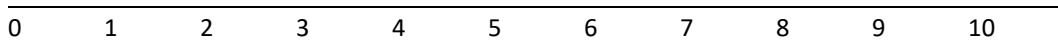


3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____%

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



What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____

Doctor Signature: _____ Reviewed on: ____/____/____

Activities Of Life

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

ACTIVITY:

EFFECT:

- | | | | | |
|-------------------------|------------------------------------|---|---|--|
| Sit to Stand | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Carry Groceries | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing Stairs | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pet Care | <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 |
| Extended Computer Use | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Household Chores | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting Children | <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 |
| Sexual Activities | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleep | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static Sitting | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Static 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 |
| Washing/Bathing | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dishes | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Yard work | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Garbage | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Concentration (Reading) | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Hobby: _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

WHAT ARE YOU HOPING TO ACHIEVE WHILE UNDER CARE?

HEALTH GOAL

SIGNIFICANCE OF GOAL

EXAMPLE: Goal: Get rid of my headaches

I want to play with my kids without pain, be able to spend more time with my family and have more energy

- | | |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

SIGNATURE: _____ DATE: ____/____/____

Doctor Signature: _____ Reviewed on: ____/____/____

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: SPRAINS/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 NAME HERE

SIGNATURE OR GUARDIAN SIGNATURE

DATE

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ Phone #: _____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW
WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. BRENTON HICKS AND ANY AND ALL MORE LIFE 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 MORE LIFE CHIROPRACTIC.

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD

DATE

WITNESS SIGNATURE (OFFICE STAFF)

DATE

Doctor Signature: _____ Reviewed on: ____/____/____

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-practice member relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimal 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 process.
- 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 need.
- E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or 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 through chiropractic .
- G. We invite you to speak frankly to the doctor or 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.

PRINT NAME HERE

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 physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES 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 disclose 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.

PRINT NAME HERE

SIGNATURE

DATE

Doctor Signature: _____ Reviewed on: ____/____/____

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 ON A DISC 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 DOCTOR OF MORE LIFE CHIROPRACTIC DOES 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 NAME HERE

DATE OF BIRTH

SIGNATURE

DATE

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

SIGNATURE: _____ Date: _____

-- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE --

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Doctor Signature: _____ Reviewed on: ____/____/____

FAMILY HEALTH HISTORY

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

1. Does anyone in your family suffer from your same condition? Yes No

If yes, Relationship(s) to you: _____

2. Any heredity conditions the doctor should be aware of? Yes No If yes, please explain:

PLEASE PRINT NAME HERE

DATE

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

Doctor Signature: _____ Reviewed on: ____/____/____