NEW PATIENT APPLICATION

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Our Mission is to serve as many people as possible with natural, safe, and effective tools to achieve their body's optimal state of LIFE expression. We provide an educational lifestyle, inspiring others to create a healthier community.

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208-906-1564
www.prehabboise.com

PATIENT HEALTH HISTORY

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

Address: _____ Sex: ☐ Male ☐ Female

City: _____ State: ____ Zip: _____ Home Phone: _____

Social Security #: _____ Cell Phone: _____

Drivers License # and state: _____ E-Mail Address: _____

Employer: _____ Business Phone: _____

Occupation: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Significant others name: _____ Significant others Employer: _____

Significant others Occupation: _____ Number & ages of Children: _____

Referred to this office by? _____ _____

Name of emergency contact: _____ Phone: _____ Relationship: _____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No (for our records we will take a copy of your insurance card)

Who is the primary card holder? _____ What is their date of birth? _____

Is patient covered by additional insurance? ☐ Yes ☐ No Please list: _____

INJURY INFORMATION

Is this injury work related? ☐ Yes ☐ No Is this injury auto related? ☐ Yes ☐ No Date of Injury: _____

GOALS FOR CARE

People see Chiropractors for a variety of different reasons. Some go for relief of pain, some to correct the cause and others for prevention. Your Doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care – Symptomatic relief of pain or discomfort

☐ Corrective Care – Correcting, relieving, stabilizing the cause of the problem.

☐ Prevention – Maintaining the body to the highest degree of health possible.

☐ I want the Doctor to select the type of care appropriate for my conditions.

List any other Doctors you have consulted for this condition:

1. _____ 2. _____

Primary Physician: _____ If needed, do we have your permission to send information regarding your care to your primary physician? ☐ Yes ☐ No

Have you received Chiropractic care before: ☐ Yes ☐ No When: _____

Patient Signature: _____ **Date:** _____

Patient Name: _____ **Date:** ____/____/____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Chief Complaint (why you're here today):_____

_____

Have you had any previous: falls, auto injuries, sports traumas, repetitive motion injuries, work related injuries, etc. ☐ Yes ☐ No
Describe: _____

Is condition: ☐ Auto Related ☐ Work Related ☐ Other ☐ No Injury Explain: _____

Date of Accident: _____ Time of Accident: _____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT

When did this condition begin? _____

Has it ever occurred before? ☐ Yes ☐ No Explain: _____

Has anything made it: Better? ☐ Yes ☐ No what: _____

Worse? ☐ Yes ☐ No what: _____

Which pain or condition is the worst? _____

TIMING: ☐ Worse AM ☐ Worse afternoon ☐ Worse at night
☐ Intermittent ☐ Constant ☐ Worse with activity

When this problem is at its worst, can you explain in your own words how exactly it feels? ☐ Yes ☐ No
Describe: _____

Does the pain radiate or travel to other areas? ☐ Yes ☐ No Describe:
_____

QUALITY: ☐ Burning ☐ Diffuse ☐ Dull / Aching ☐ Localized ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Tingling ☐ Radiating ☐ Other:
_____

How often do you find yourself suffering from this problem? _____

How long does the problem last? _____

Do you smoke or chew tobacco? ☐ Yes ☐ No ___ years ___ packs per day

MEDICATIONS: What medications are you currently taking, and for what conditions?

_____

_____

_____

_____

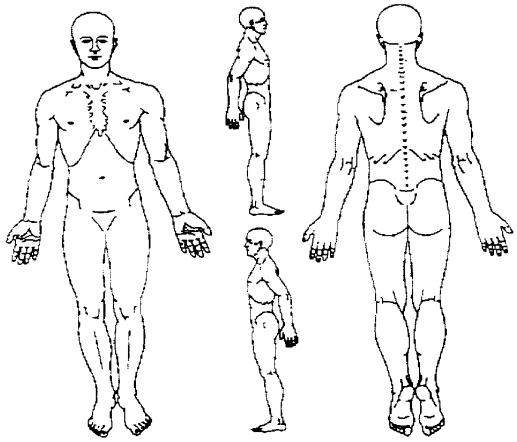
Below is a list of diseases & health problems which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all sections, mark "NONE" if none apply

Constitution:
☒ None ☒ Daytime Sleepiness ☒ Weight Gain / Loss ☒ Fatigue ☒ Chills ☒ Night Sweats ☒ Fever ☒ Loss of Memory

Eyes / Vision:
☒ None ☒ Blindness ☒ Glaucoma ☒ Blurred Vision ☒ Photophobia ☒ Vision Change ☒ Tearing ☒ Double Vision ☒ Eye Pain

Ears / Nose / Throat:
☒ None ☒ Difficulty Swallowing ☒ History of head injury ☒ Headaches ☒ Fainting ☒ Loss of smell ☒ Frequent sore throats ☒ Discharge ☒ Hoarseness ☒ Ear Pain ☒ Hearing Loss ☒ Nasal Congestion ☒ Nose Bleeds ☒ Sinus Infection ☒ Snoring ☒ Dizziness ☒ Tinnitus (ringing in ears) ☒ TMJ ☒ Rhinorrhea (runny nose)



Breathing:
☒ None ☒ Asthma ☒ Wheezing ☒ Cough ☒ Shortness of breath (SOB) ☒ Coughing up blood

Heart:
☒ None ☒ Angina ☒ Swelling of legs ☒ Heart problems ☒ Chest pain ☒ Ulcers ☒ Heart murmur ☒ Palpitations

Digestion:
☒ None ☒ Belching ☒ Heartburn ☒ Constipation ☒ Indigestion ☒ Abdominal Pain ☒ Difficulty Swallowing ☒ Hemorrhoids ☒ Vomiting ☒ Vomiting Blood ☒ Rectal bleeding ☒ Nausea ☒ Diarrhea

Female:
☒ None ☒ Cramps ☒ Vaginal Bleeding ☒ Breast lumps / pain ☒ Vaginal Discharge ☒ Burning urination ☒ Irregular menstruation ☒ Frequent urination ☒ Inability to conceive

Male:
☒ None ☒ Prostate ☒ Burning urination ☒ Erectile dysfunction ☒ Frequent urination ☒ Hesitation / dribbling

Endocrine:
☒ None ☒ Diabetes ☒ Goiter ☒ Cold intolerance ☒ Heat intolerance ☒ Hair loss ☒ Thyroid ☒ Excessive hunger ☒ Frequent urination ☒ Excessive appetite ☒ Unusual hair growth

Skin:
☒ None ☒ Itching ☒ Rash ☒ Change in nail texture ☒ Skin Lesions / Ulcers ☒ Hives ☒ Hair loss ☒ Hair growth ☒ Varicosities ☒ History of skin disorders ☒ Sensation changes

Nervous:
☒ None ☒ Dizziness ☒ Numbness ☒ Tremor ☒ Headache ☒ Seizures ☒ Strokes ☒ Limb weakness ☒ Sleep disturbance ☒ Loss of memory ☒ Walking Difficulty ☒ Loss of consciousness ☒ Slurred speech ☒ Stress

Psychological:
☒ None ☒ Insomnia ☒ Depression ☒ Behavior change ☒ Memory loss ☒ Anxiety ☒ Appetite ☒ Mood change ☒ Decreased enjoyment ☒ Confusion

Allergy:
☒ None ☒ Itching ☒ Food intolerance ☒ Anaphylaxis ☒ Sneezing ☒ Nasal congestion

Blood:
☒ None ☒ Anemia ☒ Fatigue ☒ Blood transfusions ☒ Blood clotting ☒ Bleeding ☒ Lymph Node Swelling ☒ Bruising

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Illness:
- ☒ None
- ☒ Anemia
- ☒ Cancer
- ☒ Hepatitis
- ☒ Seizures
- ☒ ADD
- ☒ Thyroid Problems
- ☒ CVA (stroke)
- ☒ Eye problems
- ☒ STD's
- ☒ Allergies
- ☒ Asthma
- ☒ CRPS (RSD)
- ☒ Hypertension
- ☒ Depression
- ☒ Fibromyalgia
- ☒ Kidney Disease
- ☒ Suicide Attempts
- ☒ Diabetes (Insulin Dep)
- ☒ Diabetes (NIDDM - NonInsulin)
- ☒ Other _____
- ☒ Chicken Pox
- ☒ Arthritis
- ☒ Liver Disease

Surgeries:
- ☒ None
- ☒ Cosmetic
- ☒ Gallbladder
- ☒ Mastectomy
- ☒ Angioplasty
- ☒ Hysterectomy
- ☒ Appendectomy
- ☒ Laminectomy
- ☒ Tonsillectomy
- ☒ D & C
- ☒ Hernia
- ☒ Spinal Fusion
- ☒ Other _____
- ☒ Caesarean Section
- ☒ Cardiovascular Other – explain: _____
- ☒ Joint Reconstruction
- ☒ Joint Replacement
- ☒ Carpal Tunnel

Ob/Gyn: Describe: _____
- ☒ None

Injuries: Describe: _____
- ☒ None

Non-Drug Allergies: Describe: _____
- ☒ None

FAMILY HEALTH HISTORY

	Alive	Deceased	Condition
Father	☒	☒	_____
Mother	☒	☒	_____
Paternal Grandfather	☒	☒	_____
Paternal Grandmother	☒	☒	_____
Maternal Grandfather	☒	☒	_____
Maternal Grandmother	☒	☒	_____
Son (s)	☒	☒	_____
Daughters (s)	☒	☒	_____
Brothers (s)	☒	☒	_____
Sisters (s)	☒	☒	_____

DAILY ACTIVITIES:

Mark any activities that are affected by your current condition:

- ☒ Care of Family Member
- ☒ Extended Computer Use
- ☒ Lifting Children
- ☒ Self Care – Dressing
- ☒ Reading / Concentration
- ☒ Changing Positions
- ☒ Self Care – Bathing
- ☒ Work Capacity
- ☒ Self Care
- ☒ Sexual Activities
- ☒ Sit to Stand
- ☒ Driving
- ☒ Pet Care
- ☒ Sleep
- ☒ Standing
- ☒ Climbing Stairs
- ☒ Household Chores
- ☒ Sitting
- ☒ Exercise
- ☒ Walking
- ☒ Other: _____

PREGNANCY RELEASE:

To the best of my knowledge I am not pregnant. I understand that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Patient Signature: _____ Date: _____

☒ Male, does not apply

CONSENT TO EVALUATE AND ADJUST MINOR CHILD:

I being the parent or legal guardian of the aforementioned minor child (patient) give permission to their evaluation, x-ray and Chiropractic care.

Childs Name (patient): _____

Signature of parent / legal guardian: _____ Date: _____

OFFICE POLICY

It is my responsibility to inform this office of any changes in my health status, insurance or my contact information.

- INSURANCE: I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. All professional services rendered are charged directly to the patient (me) and are my responsibility. We require that your examination day and 1rst adjustment charges be paid in full when services are rendered and until insurance coverage has been verified. If your yearly deductible has not been met, if any services are denied or non-covered, if your coverage becomes inactive or you have met the maximum benefit fees for services will be your responsibility. In the event that your insurance check is mailed to you we expect you to present it to this office if there are charges owed.

- CASH: Fees are paid at the time of service, unless special arrangements have been made in advance. If special arrangements are made and you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This applies to all plan types except Auto Injury and Work Injury claims.

- WORKMAN'S COMPENSATION: Report your accident to your employer, bring in the necessary insurance information, and complete and sign the appropriate forms for billing by the second visit. We will bill your insurance directly. In the event you receive the insurance check, we expect you will present the check to our office.

- AUTO INJURY: Please provide us with the accident report, your car insurance, health insurance, liable parties insurance, and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event that you receive the insurance check, we expect you will present the check to our office.

Any treatment remaining unpaid after (60) days will bear interest at the highest legal annual rate of interest allowed in Idaho until paid. If the office has to hire an attorney, collection agency or use outside means of collecting past due bills, you must reimburse the office for any attorney fees, court costs or collections spent in collecting the bill.

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to release any information deemed appropriate to any insurance company, attorney or adjuster in order to process my claims for reimbursement, and I release you of any consequence thereof. We may disclose your personal health information (PHI) to family members of close friends whom accompany you if we determine it's in your best interest so we may provide you with the best care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care. You have the right to request a restriction in how we use your or disclose your PHI.

OPEN ENVIRONMENT

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request a special appointment in one of our private rooms. A doctor or trained staff member will speak with you about your condition, concern or other matters.

TERMS OF ACCEPTANCE

We DO NOT diagnose conditions or diseases, other than vertebral subluxations.
We offer NO treatment of conditions or disease, other than vertebral subluxations.
We promise NO cure from any condition or disease.

OUR GOAL

To locate, analyze and correct spinal interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION is a detriment to life and health. Correction of the subluxation through specific chiropractic adjustment, allows the body to function at its optimal level. This allows innate healing power of the body to work at a maximum efficiency to restore, maintain and promote natural healing.

I, _____ have read the above statement and completely understand it. I do undertake chiropractic health care on this basis.

SIGNATURE _____ DATE _____

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AVOIDABLE RISKS

Some inherent risks associated with chiropractors are broken bones; this is very rare, but possible. Broken bones occur mostly in people that are 70 years and older, or people who suffer from severe osteoporosis or other unknown underlining diseases.

Other risks include vertebral dissection (stroke), which happens less than once in every 3 million adjustments. For this to occur there has to be an underlining condition or disease. Women on birth control face have a 1-20,000 chance of having a cranial stroke, regardless of receiving chiropractic care or not. With today's technology a person who experiences a stroke can have this condition resolved in the emergency room.

If you take or are taking large amounts of NSAIDS (aspirin, Tylenol, Advil, Motrin, etc.) or have been diagnosed with osteoporosis, please notify the doctor.

I have read and understand the Prehab: Health and Performance terms of engagement.

Patient: _____

Date: _____