ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

Application for Care

Name ____ Date: ____________________

Address ________________________________ City ________________ State _____ Zip ________

Home Phone _______________ Work Phone ________________ Cell Phone _________________

Referred By _____________________ E-mail ____

Occupation ________________________ Employer _______________________________________

Date of Birth ____________________ Age _________ Marital Status ☐ S ☐ M ☐ D ☐ W

Spouse's Name _____________ Spouse's Occupation ____________ # of Children/Ages __________

Previous chiropractor _________________________________ Approx. date of last visit___________

Chiropractic techniques you've had success with ____

If pregnant, how many weeks? ___ Due Date_______Name of OB/midwife_____________________

Ins Co.__________________ Policy Number__________________ Group Number _______________

Subscriber's Name_____________________________ Subscriber's Date of Birth_________________

The information in this section pertains to your history from birth to age 5, if you don't know just write "D.K."

Yes	No		Patient Comment if answer is Yes	Chiropractor's Comment
		1. Your mother's pregnancy with you		
☐	☐	Was she in good health through her pregnancy?	____________	____________
☐	☐	Have any falls or injuries during pregnancy?	____________	____________
☐	☐	Experience any physical and/or mental abuse?	____________	____________
		2. Birth Process	____________	____________
☐	☐	Was the delivery long or difficult?	____________	____________
☐	☐	Mother given drugs during delivery?	____________	____________
		Forceps or Cesarean? Breech? Circle one if it applies	____________	____________
		Home birth? Hospital birth? Circle one	____________	____________
		3. Growth and Development		
☐	☐	Were you taught how to care for your spine?	____________	____________
☐	☐	Did you fall out of bed? Did you fall down the stairs?	____________	____________
☐	☐	Were you breastfed?	____________	____________
☐	☐	Childhood sicknesses?	____________	____________
☐	☐	Accidents? Falls? Injuries?	____________	____________
☐	☐	Surgery? Drugs?	____________	____________
☐	☐	Child abuse?	____________	____________
☐	☐	Spanking (how?)	____________	____________
☐	☐	Chair pulled out when sat down?	____________	____________
☐	☐	Were you yanked by your arm?	____________	____________

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Chiropractor's Comment
☐	☐	Did/do you smoke?	____________	____________
☐	☐	Did/do you drink any alcohol?	____________	____________
☐	☐	Have you had surgery or organs removed/replaced?	____________	____________
☐	☐	Drugs? (Prescriptive or non-prescriptive)	____________	____________
☐	☐	Teeth, eye or hearing problems?	____________	____________
☐	☐	Have you been in accidents?	____________	____________
☐	☐	Exercise regularly?	____________	____________
☐	☐	Did/do you have occupational stress?	____________	____________
☐	☐	Physical stress? Mental Stress?	____________	____________
☐	☐	Hobbies/Sports injuries	____________	____________
☐	☐	Other traumas or problems?	____________	____________
☐	☐	Sleeping posture ☐ side ☐ stomach ☐ back	____________	____________

Reason for visiting us ____

If pain, when did it start? ____

Pains are ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent Getting worse? ☐ Yes ☐ No

What activities aggravate your condition/pain? ______________________________

What activities lessen your condition/pain? ______________________________

Is this condition worse during certain times of the day? ______________________

Is this condition interfering with work? ☐ Yes ☐ No Sleep? ☐ Yes ☐ No Routine? ☐ Yes ☐ No

Other doctors seen for condition ______________________________________

Any home remedies? ____

What have you heard about chiropractic care? ______________________________

Do you know what a subluxation is? Please describe __________________________

____

What daily rituals for spinal health do you practice? __________________________

Other symptoms:

☐ Headaches	☐ Pins and needles in arms	☐ Dizziness, fainting
☐ Neck Pain	☐ Pins and needles in legs	☐ Loss of smell
☐ Upper back, shoulder pain	☐ Numbness in arms, hands, fingers	☐ Loss of taste
☐ Mid back pain	☐ Numbness in legs, feet, toes	☐ Diarrhea
☐ Low back pain	☐ Shortness of breath	☐ Feet cold
☐ Hip pain	☐ Fatigue	☐ Hands cold
☐ Pain in arms, hands	☐ Depression	☐ Stomach upset
☐ Pain in legs, feet	☐ Lights bother eyes	☐ Constipation
☐ Difficulty in raising legs	☐ Loss of memory	☐ Loss of Balance

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

(904)247-3933 or (904)479-0363

TERMS OF ACCEPTANCE

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.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any 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 adjustments of the spine.

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

Vertebral Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of metal 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 chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a 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 PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I hereby authorize payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance to the doctors. I hereby authorize the attending doctor to release any information concerning my examination or treatment. If an outstanding balance is not paid within 30 days, I will be responsible for all costs incurred for collections, including reasonable attorney fees.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Name_______________________________________Signed____

Date___________________________

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Please initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

____ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

Please initial

TREATMENT AUTHORIZATION

____ I understand that if I am accepted as a patient by Alterman & Johnson Family Chiropractors, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic care will be explained to me upon my request.

____ I hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. PLEASE LEAVE THIS BLANK IF YOU ARE PREGNANT

____ I consent to receiving voicemail/text messages from Alterman & Johnson Family Chiropractors/Blooming Bellies related to my protected healthcare information at (phone number) ____________________. I understand I may be charged for such calls by my wireless carrier.

____

Print Name Date

____

Signature (Patient or Parent/Guarding)

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize of Alterman & Johnson Family Chiropractors to administer treatment as they deem necessary to my child (name)_______________________________________.

____

Parent/Guardian Signature Date

Name: ________________________________ **Today's Date**: ______________________

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: __________________________________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _________________________________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____________________________________

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: __________________________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ____________________________________

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ____________________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ____________________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: __________________________________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ____