CASTLE
HEALTH and WELLNESS
CHIROPRACTIC

New Patient Application

Welcome and thank you for applying as a patient to our clinic. We are a very unique clinic specializing in research-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health. In addition to our formal treatment methods we want you to know that your visit to us is an overall experience focused on the restorative nature of the human body. Our number one goal is for you to achieve your desired level of health. We will tailor your treatment to your specific needs and together we will achieve it.

Thank you again for applying as a patient in our clinic.

Patient/Guardian Initials: _____ Rev. 01/22

PATIENT APPLICATION

Last: _____ First: _____ Middle Int: ___ Nickname: _____

Home Address: _____ Age: ___ Sex: [ ] M [ ] F

City: _____ Zip:_____ Cell Ph: (_____)_____-_____ Cell Phone Provider:_____

Home Ph: (_____)_____-_____ Email address: _____

Birth Date: _____/_____/_____ Social Security #: _____-____-_____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: (_____)_____-_____

PURPOSE OF VISIT

Reason for appointment & related health problems:	Date Condition Started:	Have you had this before?	Injury related?
1. _____	_____	[ ] Yes [ ] No	[ ]Yes [ ] No
2. _____	_____	[ ] Yes [ ] No	[ ]Yes [ ] No
3. _____	_____	[ ] Yes [ ] No	[ ]Yes [ ] No

EXPERIENCE WITH STANDARD CHIROPRACTIC If the answer is yes, all info in green must be completed.

Have you seen a Chiropractor before? [ ] Yes [ ] No Who?_____

When? _____ Reason for visits:_____

How did you respond?_____

Did your previous chiropractor take before and after **X-Rays**? [ ] Yes [ ] No

Did your previous chiropractor tell you that **poor posture** can negatively affect your overall health? [ ] Yes [ ] No

Did your previous chiropractor make you aware of any of your **poor posture habits**? [ ] Yes [ ] No

Explain?

_____ Are you aware of poor posture habits in your **spouse or children**? [ ] Yes [ ] No

Explain? _____

OTHER PROVIDERS

Medical Doctors Seen:

Name: _____ Date of Last Visit: _____ Is this your primary care provider? [ ] Yes [ ] No

Name: _____Date of Last Visit: _____ Is this your primary care provider? [ ] Yes [ ] No

Previous surgeries (all types) and dates: _____

_____

What other testing or treatments have you tried to date for the **present condition** with location (facility) and dates of those test and/or treatments: _____

_____

Current over-the-counter medications: _____

Current prescription medications: _____

Patient/Guardian Initials: _____ Rev. 01/22

SOCIAL HISTORY AND LIFESTYLE

Do you exercise? [ ] Yes [ ] No How often? 1x 2x 3x 4x 5x per week? Other:_____

What activities? [ ] Running/Jogging [ ] Weight training [ ] Cycling [ ] Yoga [ ] Pilates [ ] Swimming

[ ] Other:_____

Do you consider yourself to be…? [ ] Underweight [ ] Normal weight [ ] Overweight [ ] Obese [ ] Severely obese

Do you smoke? [ ] Yes [ ] No How much? _____

Do you drink alcohol? [ ] Yes [ ] No How much? _____per [ ] day [ ] week [ ] month [ ] year

Do you drink caffeinated beverages? [ ] Yes [ ] No How many cups per day?_____

What supplements do you take (i.e. vitamins, minerals, herbs)?_____

HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned regions of vertebra in your spine. When these vertebrae are twisted from their normal position, they can cause physical stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing physical stress to your nerves, can weaken and distort the overall structure of your spine. This is visualized as weakened and distorted POSTURE. Postural distortions can have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome or Posture (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body).

Please check any health condition you may be experiencing **NOW** or have **EVER** experienced.

CERVICAL SPINE (NECK)

Do you have cervical spine issues? [ ]Yes [ ] No - If yes, check all that apply:

Subluxations in your neck will affect the nerves into your neck, arms, hands and head, negatively influencing these parts of your body.

[ ] Neck pain	[ ] Headaches	[ ] Pain into shoulders/ arms/	[ ]Immune system weakness
[ ] TMJ/pain/ clicking	[ ] Dizziness/fainting	hands [ ] Weakness in grip	[ ] Arthritis in the neck
[ ] Allergies/hay fever	[ ] Low energy/fatigue	[ ] Visual disturbances	[ ] Hearing disturbances
[ ]Coldness in	[ ]	[ ] Recurrent colds/flu	[ ] Thyroid conditions
hands [ ] Sinusitis	Depression [ ]	[ ] Numbness/tingling in arms/hands	[ ] Anxiety
	Allergies		

THORACIC SPINE (UPPER BACK)

Do you have thoracic spine issues? [ ]Yes [ ] No - If yes, check all that apply:

Subluxations in your upper back will affect the nerves into your heart and lungs, negatively influencing these parts of your body.

[ ] Upper back pain[ ] Shoulder pain		[ ] Heart attacks/angina	[ ] Pain on deep inspiration/expiration
[ ] Heart palpitations	[ ] Tachycardia	[ ] Shortness of breath	[ ] High blood pressure
[ ] Heart murmurs	[ ] Asthma/wheezing	[ ] High cholesterol	[ ] Recurrent lung infections/bronchitis

THORACIC SPINE (MID BACK)

Do you have thoracic spine issues? [ ]Yes [ ] No - If yes, check all that apply:

Subluxations in your mid back will affect the nerves into your ribs/chest and upper digestive tract, negatively influencing these parts of your body.

[ ] Mid back pain	[ ] Pain into ribs/crest	[ ] Scoliosis	[ ] Kidney disease	[ ] Diabetes
[ ] Ulcers/gastritis	[ ] Indigestion/heartburn	[ ] Hypoglycemia	[ ] Gall bladder problems	[ ] Nausea
[ ] Acid reflux	[ ] Tired/Irritable after eating or when you haven't eaten for a while			[ ] Liver disease

LUMBAR SPINE (LOW BACK)

Do you have lumbar spine issues? [ ]Yes [ ] No - If yes, check all that apply:

Subluxations in your low back will affect the nerves into your legs/feet and pelvic organs, negatively influencing these parts of your body.

[ ] Low back pain	[ ] Pain into hips/legs/feet	[ ] Weakness/injuries in hips/knees/ankles
[ ] Numbness/tingling in legs/feet	[ ] Muscle cramps in legs/feet	[ ] Recurrent bladder/urinary tract infections
[ ] Coldness in your legs/feet	[ ] Frequent/difficulty urinating	[ ] Menstrual irregularities/cramping (females)
[ ] Constipation	[ ] Diarrhea	[ ] Sexual dysfunction

Please list any health conditions not mentioned: _____

_____ Have you ever been diagnosed with cancer? [ ] Yes [ ] No If yes, explain: _____

_____

HISTORY OF PRIMARY COMPLAINTS

Is this the first time you have had this pain? [ ] Yes [ ] No If yes, explain: _____

_____

How did the CURRENT episode of pain/discomfort occur? _____

_____

How did the FIRST episode of pain/discomfort occur? _____

_____

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain Location:_____		Pain Location: _____		Pain Location: _____	
RIGHT NOW:	_____/10	RIGHT NOW:	_____/10	RIGHT NOW:	_____/10
At its WORST:	_____/10	At its WORST:	_____/10	At its WORST:	_____/10
At its BEST:	_____/10	At its BEST:	_____/10	At its BEST:	_____/10
At its AVERAGE:	_____/10	At its AVERAGE:	_____/10	At its AVERAGE:	_____/10

What makes your pain DIMINISH? (Check all that apply):

[ ] Nothing	[ ] Ice	[ ] Heat	[ ] Massage/Rubbing	[ ] Exercise/Activity	[ ] Sitting
[ ] Standing	[ ] Rest	[ ] Stretching	[ ] "Popping" the joints	[ ] Bracing/Taping	[ ] Laying

[ ] Other: _____

[ ] Over-The-Counter Medications: _____

[ ] Prescription Medications: _____

What makes it WORSE? (Check all that apply):

[ ] Coughing	[ ] Sneezing	[ ] Bearing Down	[ ] Sexual Intercourse	[ ] Running	[ ] Standing
[ ] Lifting	[ ] Bending	[ ] Pushing	[ ] Pulling	[ ] Driving	[ ] Sitting
[ ] Walking	[ ] Laying Down	[ ] Movement of the head		[ ] Movement of the low back	

[ ] Other: _____

Patient/Guardian Initials: _____ Rev. 01/22

Bladder Function: if you have had any change in your bladder function, do you: [ ] Not Applicable

[ ] Urinate more often [ ] Have loss of control or accidents [ ] Have a sense of urgency
[ ] Have problems with sexual function [ ] Have a loss of sensation around the groin or buttocks

How would you describe your pain?

[ ] Dull [ ] Achy [ ] Stiff [ ] Intense [ ] Throbbing [ ] Sharp [ ] Sharp with movement
[ ] Stabbing [ ] Shooting [ ] Burning [ ] Constricting [ ] Annoying [ ] Tight [ ] Unbearable
[ ] Other: _____

Pain Quality: How would you describe your pain/discomfort (check all that apply)?

Location: [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
_____ [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
Location: [ ] Constant [ ] Frequent [ ] Occasional [ ] Seldom
_____

Radiating: Does your pain seem to radiate from the primary area? [ ] Yes [ ] No If yes, where does the pain radiate to?
_____

Numbness/Tingling (pins and needles): Do you experience or have you recently experienced numbness and or tingling anywhere? [ ] Yes [ ] No Please describe where and when you feel these symptoms: _____
_____

Is your pain/discomfort WORSE:

[ ] in the morning
[ ] in the afternoon
[ ] in the evening
[ ] while sleeping
[ ] while awake
[ ] It does not seem to be affected by the time of day

Is your pain/discomfort BETTER:

[ ] in the morning
[ ] in the afternoon
[ ] in the evening
[ ] while sleeping
[ ] while awake
[ ] It does not seem to be affected by the time of day

FAMILY HEALTH HISTORY

Have any of your **biological family members** ever been diagnosed with the following:

[ ] Heart Disease	[ ] Neurological Problems	[ ] Lung Disease	[ ] Thyroid	[ ] Arthritis
[ ] Circulatory Problems	[ ] Immune System Problems	[ ] Heart Murmur	[ ] Back Pain	[ ] Cancer
[ ] High Blood Pressure	[ ] Mental Health Disease	[ ] Epilepsy/Seizures	[ ] Stroke	[ ] Diabetes
[ ] Kidney Disease	[ ] Autoimmune Disorders	[ ] Migraine Headaches	[ ] Osteoporosis	[ ] Scoliosis
[ ] Liver Disease	[ ] Digestive Disorders	[ ] Gall Bladder	[ ] Broken Bones/Fractures	
[ ] Infectious Diseases	[ ] Other:_____			

Family History	Present Age	Age at Death	Medical Problems / Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son/Daughter	_____	_____	_____
Son/Daughter	_____	_____	_____

FORWARD HEAD SYNDROME

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend/shift forward with progressive muscle weakening and stretching of your spinal cord). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or development of a "hump" at the base of your neck? **[ ] Yes [ ] No**

IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Cell Ph: _____ Hm Ph: _____ Wk Ph: _____

INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance? [ ] Yes [ ] No Policy # _____ Group #_____

Insurance Co. Name _____ Phone # _____

Address _____

Insured's Name _____ Birth Date: _____/____/_____ Relationship _____

For Automobile Accidents, what is the name of your insurance carrier? _____

Phone # _____ Policy Claim Number _____

For Work Injury, what is your Employer Contact Name _____Phone: _____

Claim No _____ If known, Insurance Carrier:
_____

Other than yourself, who else should receive charges on your accounts? (Check all that apply)

[ ] Spouse [ ] Parent/Guardian [ ] Workers Comp [ ] Auto Ins. [ ] Medicare [ ] Personal Health Ins.

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office **chooses** to bill my services to my insurance carrier this is done strictly as a **convenience** and **courtesy** for me. This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services.

I also understand that I will be charged $25 for any and all schedules appointments that are missed without contacting the office in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/Guardian: _____Date:_____

CONSENT FORMS

RADIOGRAPHIC CONSENT

In order to best determine the cause and extent of my underlying spinal problems, I hereby give my consent to allow Castle Health & Wellness Chiropractic and/or its associates and assistants to take spine or other relevant radiographs as deemed clinically necessary through chiropractic history/examination and in accordance with clinical usage indications as published in the Practicing Chiropractors Committee on Radiology Protocols for Biomechanical Assessment of Spinal Subluxation in Chiropractic Clinical Practice (2009).

Signature of Patient/Guardian: _____Date:_____

ALL FEMALES: I also hereby declare to my knowledge that I am NOT pregnant _____.
Initial

AUTHORIZATION OF CARE

I authorize and agree to allow the doctor and/or assistant to work with my spine through the use of spinal adjustments and rehabilitative exercises, traction and other methods for the sole purpose of postural and structural improvement in biomechanical and related neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The doctor and/or assistant will not be held responsible for any health conditions or diagnosis which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or assistant's specific recommendations at this clinic that I will not receive the full benefit from this program, and that if I terminate my care prematurely that all fees incurred will be due and payable at the time. I authorize the assignment of all insurance benefits be directed to Castle Health and Wellness Chiropractic, its associated doctors and/or assistants for all services rendered.

Signature of Patient/Guardian: _____Date:_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strains, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries in the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks of complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have an opportunity to discuss with the doctor and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Patient Name: _____

Signature of Patient/Guardian: _____Date:_____

HEALTHCARE AUTHORIZATION FORM (HIPPA)

THE FOLLOWING AUTHORIZES CASTLE HEALTH & WELLNESS CHIROPRACTIC AND ASSOCIATES TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Castle Health & Wellness Chiropractic and associates to use my name , address, phone numbers, photo and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Castle Health & Wellness Chiropractic and associates to treat me in an open room where other patients are also being treated. I am aware that other person in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or assistant in private, the doctor or assistant will provide a private room for these conversations.

By signing the following you are giving Castle Health & Wellness Chiropractic and associates permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/Guardian: _____Date:_____

MISSED APPOINTMENT FEE

By signing below, I understand that if I do not give Castle Health and Wellness Chiropractic a 24 hour notice prior to rescheduling or canceling my appointment, I will be responsible for the $25 missed appointment fee.

Signature of Patient/Guardian: _____Date:_____

Patient/Guardian Initials: _____