APPLICATION FOR CARE
Alive Chiropractic
12930 W Bluemound Rd
Elm Grove, WI, 53122
262.955.8867

Today's Date: _____/_____/_____

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

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

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Email Address: _____

Occupation: _____ Employer's Name: _____

Do you Have Insurance: ☐ Yes ☐ No Primary Insurance: _____

Secondary Ins.: _____ Name of Insured: _____

☐ Single ☐ Divorced ☐ Widowed ☐ Married Spouse's Name: _____

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, when?:_____

How did you hear about our office?: _____ **Health History:**

Please ✔ check all symptoms you've ever experienced, even if they do not seem related to your complaint:

___ Headaches	___ Asthma	___ Ulcers	___ Depression	___ Foot (L/R)
___ Ear Infections	___ Sexual Dysfunction	___ Epilepsy	___ Diarrhea	___ Allergies
___ Sinus Issues	___ Heart Attack	___ Convulsions	___ Scoliosis	___ Bladder Problems
___ Kidney Problems	___ Shoulder Pain (L/R)	___ GERD/Acid Reflux	___ Spinal Fracture	___ Arthritis/Joint Pain
___ Migraines	___ Loss of Energy	___ Mid Back Pain	___ Bone Fracture	___ Fibromyalgia
___ Hearing Loss	___ Difficulty Breathing	___ Anxiety	___ Sciatic Pain (L/R)	___ High Blood Pressure
___ Frequent Colds	___ Infertility	___ Stomach Issues	___ Loss of Balance	___ Low Blood Pressure
___ Menstrual Problems	___ Heart Problems	___ Tremors	___ Constipation	___ Numb/Tingling
___ Jaw/TMJ Pain	___ Elbow/Wrist Pain	___ Chest Pain	___ Poor Posture	Arms/Hands (L/R)
___ Ringing in the Ears	___ Sleep Problems	___ Lower Back Pain	___ Spinal Surgery	___ Numb/Tingling
___ Thyroid Issues	___ Nausea	___ Nervousness	___ Knee (L/R)	Legs/Feet (L/R)
___ Prostate Problems	___ Seizures	___ Digestive Issues	___ ADD/ADHD	
___ Stroke	___ Upper Back Pain	___ Disc Problems	___ Bed Wetting	
___ Neck Pain	___ Double Vision	___ Cancer	___ Skin Problems	
___ Dizziness	___ Blurry Vision	___ Hip/Leg Pain (L/R)	___ Diabetes (1 or 2)	

Main Complaint: _____

List any medications you are taking: _____

Have you been in a car accident recently? ☐ Yes ☐ No If so, when?: _____

The statements made on these forms are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

Activities of Daily Living: Regarding your **MAIN COMPLAINT**

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities. For each item below, **please check ONE box from each section** which most closely describes your condition right now. We realize that you may consider that two of the statements in any one section relate to you, but please just check **ONE** box that most closely describes your current condition.

Section 1: Pain Intensity ☐ The pain comes and goes and is very mild. ☐ The pain is mild and does not vary much. ☐ The pain comes and goes and is moderate. ☐ The pain is moderate and does not vary much. ☐ The pain comes and goes and is very severe. ☐ The pain is severe and does not vary much.	**Section 6: Standing** ☐ I can stand as long as I want without pain. ☐ I have some pain when standing, but it does not increase with time. ☐ I cannot stand for longer than one hour without increasing pain. ☐ I cannot stand for longer than ½ hour without increasing pain. ☐ I avoid standing because it increases the pain right away.
Section 2: Personal Care ☐ I would not have to change my way of washing or dressing in order to avoid pain. ☐ I do not normally change my way of washing or dressing even though it causes some pain. ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it. ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it. ☐ Because of the pain, I am unable to do some washing and dressing without help. ☐ Because of the pain, I am unable to do any washing and dressing without help.	**Section 7: Sleeping** ☐ I get no pain in bed. ☐ I get pain in bed, but it does not prevent me from sleeping well. ☐ Because of pain, my normal night's sleep is reduced by less than 25%. ☐ Because of pain, my normal night's sleep is reduced by less than 50%. ☐ Because of pain, my normal night's sleep is reduced by less than 75%. ☐ Pain prevents me from sleeping at all.
Section 3: Lifting ☐ I can lift heavy weights without extra pain. ☐ I can lift heavy weights, but it causes extra pain. ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table). ☐ Pain prevents me from lifting heavy objects off the floor. ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ☐ I can only lift very light weights at the most.	**Section 8: Social Life** ☐ My social life is normal and gives me no pain. ☐ My social life is normal, but increases the degree of pain. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests. ☐ Pain has restricted my social life and I do not go out very often. ☐ Pain has restricted my social life to my home. ☐ I have hardly any social life because of the pain.
Section 4: Walking ☐ I have no pain from walking. ☐ I have some pain when walking, but it does not increase with distance. ☐ I cannot walk more than one mile without increasing pain. ☐ I cannot walk more than ½ mile without increasing pain. ☐ I cannot walk at all without increasing pain.	**Section 9: Traveling** ☐ I get no pain while traveling. ☐ I get some pain while traveling, but none of my usual forms of travel makes it any worse. ☐ I get extra pain while traveling, but it does not compel me to seek alternate forms of travel. ☐ I get extra pain while traveling, which compels me to seek alternate forms of travel. ☐ Pain restricts all forms of travel. ☐ Pain prevents all forms of travel except that done lying down.
Section 5: Sitting ☐ I can sit in any chair as long as I like. ☐ I can only sit in my favorite chair as long as I like. ☐ Pain prevents me from sitting more than one hour. ☐ Pain prevents me from sitting more than ½ hour. ☐ Pain prevents me from sitting more than 10 minutes. ☐ I avoid sitting because it increases pain right away.	**Section 10: Changing Degree of Pain** ☐ My pain is rapidly getting better. ☐ My pain fluctuates, but is definitely getting better. ☐ My pain seems to be getting better, but improvement is slow. ☐ My pain is neither getting better nor worse. ☐ My pain is gradually worsening. ☐ My pain is rapidly worsening.

Print Name: _____ Signature & Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

Quadruple Visual Analogue Scale

Please **circle** the number that best describes the question asked for your **MAIN COMPLAINT.**

1. How would you rate your pain **RIGHT NOW**?

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

2. What is your typical **AVERAGE** pain?

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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

No pain _____Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

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 physicians 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.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

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: sprain/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 the 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.

- I authorize and request payment of insurance benefits directly to Robert Fugiel, D. C., and any and all providers at Alive Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below

Written Consent For A Child

Name of patient who is a minor/child: _____

I authorize Dr. Robert Fugiel and any and all Alive 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 Alive Chiropractic.

Parent/Guardian Signature: _____ Date:_____

Relationship to Minor/Child: _____

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 on a disc for a $5 fee. This fee must be paid in advance.

PLEASE NOTE: X-rays are utilized in this office to help locate and analyze **vertebral subluxations**. The doctor(s) of Alive 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 Full Legal Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if under 18 years)

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Alive Chiropractic.

Signature: _____ Date: _____