# Patient Application

Welcome to Mountain View Chiropractic Center. We specialize in assisting our patients to achieve their highest level of health through our wellness and nutritional programs. Our approach is very unique and advanced from other programs because we address all 6 health interferences. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance. We look forward to serving you.

Signature:____________________________________

Date:________________________________________

# Confidential patient information

Name:______________________________ Age:________ Birth date:_________________

Address_____________________________________ Phone_______________________

City:________________ State:_____ Zip:___________Email:_______________________

Job Type:_______________________________ SS#:______________________________

Marital Status________________________ # of children____________________________

How were you referred to this office?_____________________________________________

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Reason For Visit : ❑ Musculo-Skeletal Evaluation ❑ Laser Treatment ❑ Biocleanse Footbath

❑ CBT Allergy Evaluation ❑ Nutritional Consult ❑ Hormone Balancing

Are you most interested in: ❑ Symptomatic Relief ❑Corrective Care ❑ Wellness Care

## Patient History

**Important! Please fill out completely! If you need help, Please ask.**

Primary Complaint:__________________________________________________________

Date of Onset: _________________Is this visit accident related: ❑ Yes ❑ No

What has been done previously to solve this problem_________________________________

________________________________________________________________________

Have you ever been to a chiropractor before? ❑ Yes ❑ No Who?_____________________

When? ______________Same Complaint? ❑ Yes ❑ No Results?_____________________

List Dates of Auto Accidents:_______________________________________________

List all other accidents: (sports, work, recreation…)___________________________________

Any other Health Problems/Illnesses/Hospitalizations/Surgeries_________________________

________________________________________________________________________

Is there any possibility of current pregnancy? ❑ Yes ❑ No (Please Initial)_________

# Health Lifestyle

| Medications | Allergies | Vitamins/ Herbs / Minerals |
|---|---|---|
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |

Have you ever suffered a life threatening allergic reaction? Yes No Allergen___________________________

| Exercise | Work Activity | Habits | |
|---|---|---|---|
| ❑ None | ❑ Sitting | ❑ Smoking | Packs/day_____________ |
| ❑ Minimal | ❑ Standing | ❑ Alcohol | Drinks/week_____________ |
| ❑ Moderate | ❑ Light Labor | ❑ Coffee | Cups/day______________ |
| ❑ Heavy | ❑ Heavy labor | ❑ High Stress | Reason________________ |

# Health Conditions

Cervical Spine (Neck):
Postural distortions from subluxations in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent Colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

Thoracic Spine (Upper Back):
Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ❑ Heart Palpitations
- ❑ Heart murmurs
- ❑ Tachycardia
- ❑ Heart attacks/Angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

Thoracic Spine (Mid Back):
Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ❑ Mid back pain
- ❑ Pain into ribs/chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/irritable after eating

Lumbar Spine (Low Back):
Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps un your legs/feet
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Constipation/Diarrhea
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low Back Pain

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We are dedicated to helping you reach your health goals, so we ask that you take a moment and check your present health goals:

- ❑ Get out of pain
- ❑ Get out of pain, but I am interested in learning about wellness care and how it can improve my health
- ❑ Reaching optimum health and wellness

# AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor to work with my spine through the use of spinal adjustment and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand and agree that health and accident policies are and arrangement between an insurance carrier and my-self. Furthermore, I understand that Mountain View Chiropractic will assist me in making collection from the insurance company by assisting me with forms and reports, however, I understand that the submittal to the insurance company is performed at the discretion of Mountain View Chiropractic. I understand that any amount authorized to be paid to Mountain View Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also under-stand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be im-mediately due and payable. In the event of nonpayment I understand that all fees associated with the collection of this account to include attorney fees, collection costs, court fees and court cost, should be added to the base amount owed.

The Doctor will not be held responsible for any health conditions or diagnoses 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 specific recommendations at this clinic that I will not receive the full benefit from these programs. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

______________________________________________ ________________________________________

Patient's signature Date Parent/Guardian

# IN CASE OF EMERGENCY CALL:

Name________________________________________

Relationship__________________________________

Work Phone__________________________________

Home Phone__________________________________

Cell Phone___________________________________

# INSURANCE INFORMATION

Name of Insurance Co.________________________________ Policy#______________________________

Address_______________________________________________ Phone#____________________________

Insured's Name_________________________________________ Insured's SS#_______________________

Relationship to Insured_________________________________ Birth date__________________________

Employer______________________________________________________________________________

WHO SHOULD RECEIVE THE CHARGES ON YOUR ACCOUNT?

❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Workers Comp ❑ Auto Insurance

❑ Medicare ❑ Personal Health Insurance