Start time:

T, C/D, E, X

RENEGADE CHIROPRACTIC

New Practice Member Application

Name: _____ Date of Birth: _____ Age: _____ ◯ M ◯ F

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

Cell Phone: _____ Home Phone: _____

Social Security #: _____ Email: _____

Occupation _____ Employer's Name _____

Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed Spouse's Name _____

Number of Children ____ Names, Ages, & Gender _____

Whom may we thank for referring you? _____

List The Health Concerns That Brought You Into This Office

Health Concern(s): List according to severity.	Rate of Severity 0 - no pain 10 = unbearable	When did this problem start?	Have you had this problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? ◯ Yes ◯ No If Yes: ◯ Chiropractor ◯ Medical Doctor ◯ Other _____

Who? _____ When? _____ Results? _____

Please Mark **"P"** For In the **Past** or Past Mark **"C"** For **Currently** Have:

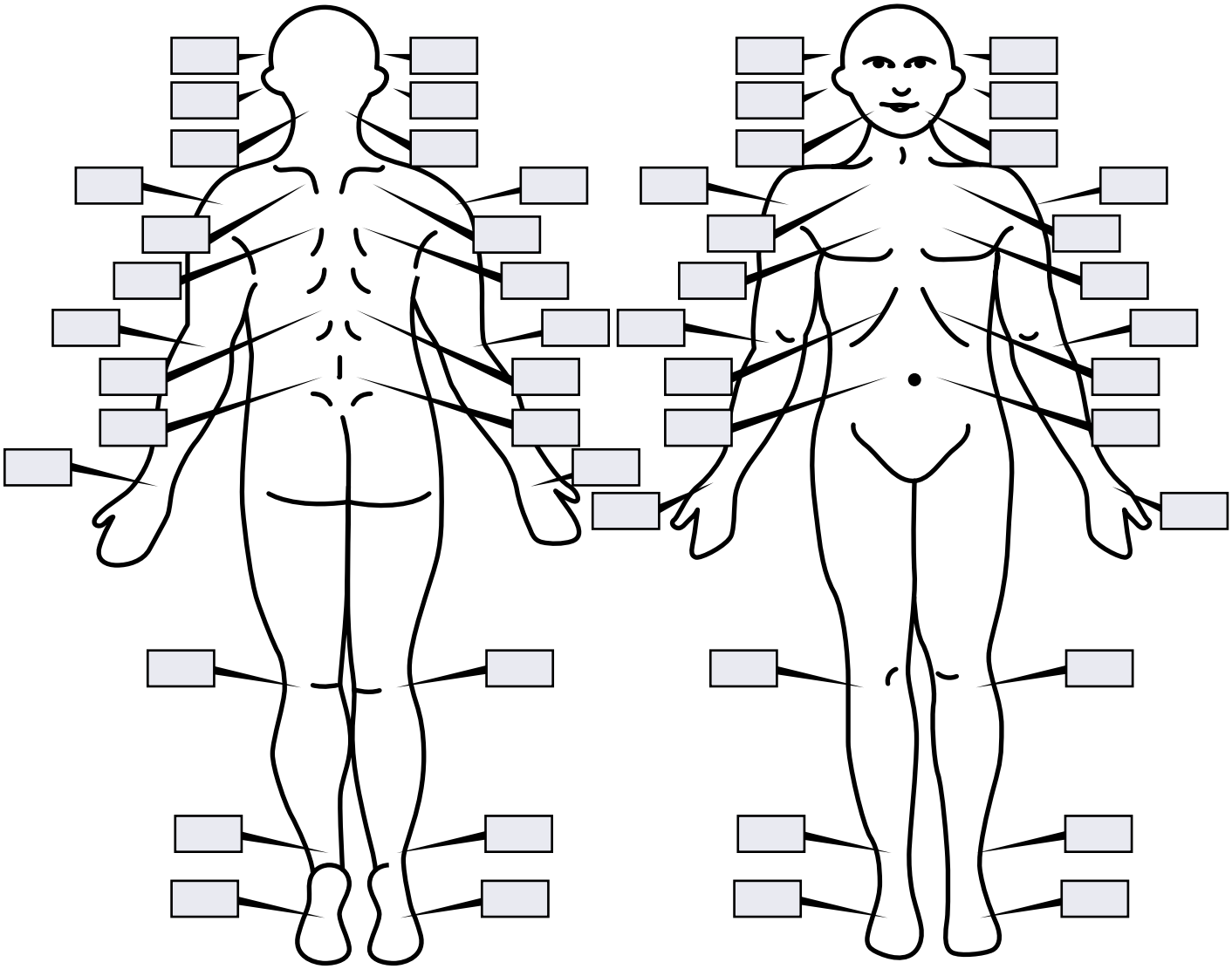
☐ Headaches	☐ Ear Infections	☐ Sinus Issues	☐ Kidney Problems	☐ Sexual Dysfunction
☐ Migraines	☐ Hearing Loss	☐ Frequent Colds	☐ Bladder Problems	☐ Sleep Problems
☐ Jaw/TMJ Pain	☐ Ringing in the Ears	☐ Thyroid Issues	☐ Menstrual Problems	☐ Tight/Sore Muscles
☐ Neck Pain	☐ Dizziness	☐ Asthma	☐ Prostate Problems	☐ Sports Injury
☐ Shoulder Pain	☐ Loss of Energy	☐ Chest Pain	☐ Infertility	☐ Sciatica
☐ Arm Pain	☐ Nervousness	☐ Heart Problems	☐ Fibromyalgia	☐ Arthritis/Joint Pain
☐ Upper Back Pain	☐ Double/Blurry Vision	☐ Nausea	☐ Epilepsy/Convulsions	☐ GERD/Gastric Reflux
☐ Mid Back Pain	☐ Anxiety	☐ Ulcers	☐ Tremors	☐ Numb/Tingling in Arms/Hands
☐ Lower Back Pain	☐ ADD/ADHD	☐ Digestive Issues	☐ Disc Problems	☐ Numb/Tingling in Legs/Feet
☐ Hip/Leg Pain	☐ Loss of Balance	☐ Diarrhea	☐ Scoliosis	☐ Stomach Problems
☐ Knee Pain	☐ Depression	☐ Constipation	☐ Poor Posture	☐ High/Low Blood Pressure
☐ Foot Pain	☐ Allergies	☐ Bed Wetting	☐ Skin Problems	☐ Difficulty Breathing
☐ Stroke	☐ Cancer	☐ Heart Attack	☐ Spinal Surgery	☐ Spinal Bone Fracture
☐ Scoliosis	☐ Diabetes	☐ Arthritis	☐ Seizures	☐ Pregnant? Due Date: ____

☐ Other _____

Symptom Chart

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching
N = Numbness **S** = Sharp/Stabbing **T** = Tingling



What relieves your symptoms?

List all surgical operations and years:

What makes your symptoms feel worse?

Have you ever been in an auto accident? List all:

When is the problem(s) at it's worst?

☐ AM ☐ PM ☐ Mid-Day ☐ Late-PM

List any other injuries to your spine, minor or major, that the doctor should know about:

List all over the counter & prescription medications you are on & the reason for each:

Have you ever been knocked unconscous? ◯ Yes ◯ No

Have you ever fractured a bone? ◯ Yes ◯ No

If yes to either of these, please describe:

Other trauma:

Social History

	How Often?			
	Daily	Weekends	Occasionally	Never
Smoking	◯	◯	◯	◯
Alcohol	◯	◯	◯	◯
Exercise	◯	◯	◯	◯

Have you consumed any caffeine or products with caffeine in the last 48 hours

◯ Yes ◯ No

Quadruple Visual Analogue Scale

Please enter the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

Use a sliding scale with zero being no pain and ten being unbearable pain.

	How would you rate your pain RIGHT NOW?	**What is your typical or AVERAGE pain?**	**What is your pain level at its BEST?** (How close to 0 does your pain get at its best?)	**What is your pain level at its WORST?** (How close to 10 does your pain get at its worst?)
Symptom 1				
Symptom 2				
Symptom 3				
Symptom 4				

What percentage of your awake hours is your pain at its **best?**

What percentage of your awake hours is your pain at its **worst?**

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

	Effect			
Activity	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Sit on Stand	○	○	○	○
Climbing on Stairs	○	○	○	○
Driving	○	○	○	○
Extended Computer Use	○	○	○	○
Household Chores	○	○	○	○
Lifting Children	○	○	○	○
Dressing	○	○	○	○
Shaving	○	○	○	○
Sexual Activities	○	○	○	○
Sleep	○	○	○	○
Static Sitting	○	○	○	○
Static Standing	○	○	○	○
Walking	○	○	○	○
Washing/Bathing	○	○	○	○
Sweeping/Vacuuming	○	○	○	○
Yard Work	○	○	○	○
Garbage	○	○	○	○
Concentration (Reading)	○	○	○	○

List Restricted Activity	Current Activity Level	Usual Activity Level

Doctor's Signature

Family Health History

This form is to assist the doctors by providing past health history information for their review.

	Effect				
Condition	Spouse	Son	Daughter	Mother	Father
Headaches	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐
Jaw/TMJ Pain	☐	☐	☐	☐	☐
Shoulder Pain	☐	☐	☐	☐	☐
Back Pain	☐	☐	☐	☐	☐
Hip/Leg Pain	☐	☐	☐	☐	☐
Arthritis/Joint Pain	☐	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐	☐
Loss of Energy	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐
Blurred/Double Vision	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Sinus Issues	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Breathing Problems	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐
High/Low Blood Pressure	☐	☐	☐	☐	☐
Stomach Problems	☐	☐	☐	☐	☐
Bed Wetting	☐	☐	☐	☐	☐
Infertility	☐	☐	☐	☐	☐
Sciatica	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Poor Posture	☐	☐	☐	☐	☐
Sleep Problems	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐

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 Taylor Dietz, D.C. 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 practice member. 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 (If having trouble, feel free to sign when you arrive)

Date

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

Name of practice member who is a minor/child:

I authorize Dr. Taylor Dietz and any and all Renegade 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 Renegade Chiropractic.

Guardian Signature (If having trouble, feel free to sign when you arrive)

Date

Relationship to Minor/Child

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 (HIPPA). 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 _____

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 in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Renegade 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 Name _____ Date of Birth _____

Signature (If having trouble, feel free to sign when you arrive) _____ Date _____

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

Signature (If having trouble, feel free to sign when you arrive) _____ Date _____

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbars (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion Extension:		
Obliques:		