PATIENT APPLICATION SURVEY

Date_____

Name_____ Age_____ Gender: M F

(First Name, Middle Inital, Last Name)

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

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

Names of Children: _____ Ages _____

Occupation: _____ Employer Name: _____

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

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Insurance Type: ___Health ___Medicare ___Medicaid ___Personal Injury ___Worker's Compensation ___None

PURPOSE OF THIS VISIT

Reason for this visit - Main Complaint: _____

Is this purpose related to an auto accident / work injury? ____ Yes ____ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything which is relieved your symptoms? _____ Yes _____ No Describe: _____

_____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ____Arm ____Leg ____Does not radiate -- Is this condition getting worse? _____(Y/N)

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: ____Work ____Sleep ____Hobbies ____ Daily Routine

Explain: _____

Have you experienced this condition before? ____Yes ____ No If so, Please explain: _____

_____

Who have you seen for this? _____What did they do? _____

How did you respond?_____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ____ Yes ____No Who? _____ When? _____

Reasons for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ____Yes ____No

Did you know posture determines your health? ____Yes ____No

Are you aware of any of your poor posture habits? ____Yes ____No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? ____Yes ____No

Explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed

a rounding of your shoulders or a developing "hump" at the base of your neck? _____Yes ____No

HEALTH 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 smoke? ____ Yes ____No How much _____
Do you drink alcohol? ____ Yes ____ No How much / week? _____
Do you drink coffee? ____ Yes ____ No How many cups / day? _____
Do you take any supplements (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 the vertebrae in your spine. When these vertebrae are twisted from their normal position they will cause 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 stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body.) Please check and health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

___ Neck Pain
___ Hearing disturbances
___ Headaches
___ Dizziness
___ Coldness in hands
___ Thyroid conditions
___ Sinusitis
___ Visual disturbances
___ Weakness in grip
___ Pain into your shoulders/arms/hands
___ Numbness/tingling in arms/hands
___ Depression

Explain:

_____

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) 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
___ Asthma/Wheezing
___ Shortness Of Breath
___ Heart Attacks/Angina
___ Pain On Deep Inspiration/Expiration
___ Recurrent Lung Infections/Bronchitis

Explain:

_____

THORACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting form Forward Head Syndrome) 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 Your Ribs/Chest
___ Indigestion/Heartburn
___ Reflux
___ Nausea
___ Ulcers/Gastritis
___ Hypoglycemia
___ Tired/Irritable after eating or when you haven't eaten for a while

Explain:

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) 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 in your legs/feet
___ Constipation/Diarrhea
___ Low back pain
___ Weakness/injuries in your hips/knees/ankles
___ Recurrent bladder infections
___ Frequent/difficulty urinating
___ Menstrual irregularities/cramping (females)
___ Sexual dysfunction

Explain:

Please list any health conditions not mentioned:

Please list any medications currently taking and their purpose:

Medications:	Purpose:	Medications:	Purpose:

Please list all past surgeries:

Please list all previous accidents and falls:

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. 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 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 mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a 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 and ability to heal. Our only method is specific adjusting to correct vertebral subluxation combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Spring Hill Chiropractic for x-ray, is for

examination only and the x-rays will remain the property of this office.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Daniel Harding and his associates have permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child
Date of last menstrual cycle:_____

_____ _____
Signature Date

Consent to x-ray:

I hereby grant Spring Hill Chiropractic permission to perform an x-ray evaluation if needed of _____
I understand that x-rays are being performed to locate vertebral subluxation and not to diagnose or treat any other disease or condition.

_____ _____
Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent of legal guardian of _____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. Spring Hill Chiropractic will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balance. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

_____ _____
Signature Date