Khorrami Chiropractic Wellness Center

PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through spinal and postural corrective programs. Our approach is very unique and more advanced than other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____

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PATIENT INFORMATION

PLEASE PRINT CLEARLY: Today's Date: _____

Full Name: _____ Email: _____ May we e-mail you? Y ___ N ___

Gender: M___ F___ Age: _____DOB:____/____/_____ Marital Status: S ___M ___D ___ W___ # Children: _____

Work Status: FT __PT __R __Student__

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

Home Phone: (_____) _____Cell Phone: (_____) _____Social Security#:_____

Driver's License#:_____

Females: Last Menstrual Period: ____/____/____ Pregnant: Y_____ N _____

Employer: _____Occupation:_____

Work Phone (_____) _____ Employer Address: _____City:_____Zip:_____

Spouse, Parent, or Guardian Name: _____ Age: ____ DOB: _____/_____/_____

Spouse's Employer: _____ Occupation:_____ Work Phone: (_____)_____

Emergency Contact Person:_____ Relationship to Patient:_____

Do you have health Insurance: Y ___ N ___ Carrier Name: _____Group Name:_____

Policy#_____Group #_____ Ins Card Copied? Y ___ N ___ DL Copied? Y ___ N ___

Who may we thank for referring you to us? Internet ___Doctor ___ Friend___ Name/Email:_____

Please initial acknowledging that the patient is responsible for the patient portion of insurance charges and/or payment in full for non-covered items and services. If there is no insurance coverage, the patient is responsible for balance of service at time of service each visit: _____

We want you to know how your Protected Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we begin care, please read and sign this consent form stating understanding and acknowledgement regarding how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning of the privacy of your PHI, please ask us for our complete HIPAA Privacy Notice. It is available, upon request, at the front desk.

The patient understands and agrees that Khorrami Chiropractic Center will use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare options and coordination of care.

The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. Patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Khorrami Chiropractic Center is not obligated to comply with those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

For your security and right to privacy, the staff has been trained in the area of patient privacy and a privacy official has been designated to insure these procedures are followed in our office. We have taken precautions to assure that your records are not readily available to those unauthorized to access them.

I have read and understand how my PHI will be used and I agree to these policies and procedures. Signature required on last page.

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PURPOSE OF THE VISIT

Health Concerns: Please list in priority order. (Use the back of the questionnaire and additional paper if needed)

	Health Issue(s)	Date Condition Started	Frequency	Severity (0-10)
1.				
2.				
3.				

Treatment: What type of treatment are you looking for? (Please check all that apply)

Symptom Relief ___ Corrective Care ___ Total Wellness Care ___

Have you previously been treated for this condition by another provider? Y ___ N ___

If yes, by whom? _____Treatment received? _____

Have you had any reaction to previous treatment? Y ___ N ___

If yes, please describe: _____

If this is a recurrence, when did you initially notice this problem? _____

Symptoms/Complaints: (Relating to your primary complaints)

When did symptoms begin? _____ What initiated the symptoms?_____

Are these conditions getting worse? Y ___ N ___
Is this? Constant ___ Frequent ___Occasional ___ Activity Related ___

How would you describe your pain/discomfort? (check all that apply)
Dull ___ Achy ___ Throbbing ___ Stiff ___ Sharp ___ Stabbing ___ Shooting ___
Intense ___ Burning ___ Constricting ___ Other___ (please describe) _____

Does your condition interfere with?
Work ___ Sleep ___ Hobbies ___ Daily Routine ___ (please describe) _____
What activities aggravate your symptoms?
Coughing ___ Sneezing ___ Bearing Down ___ Lifting ___ Bending ___ Pushing ___ Pulling ___ Driving ___
Sitting ___ Walking ___ Running ___ Standing ___ Laying down ___ Movement ___

Is there anything which has relieved your symptoms? Y ___ N ___ If yes, which of the following have helped:
Ice ___ Heat ___ Massage ___ Resting ___ Exercise ___ Sitting ___ Standing ___
Bracing/Taping ___ Stretching ___ Popping Joints ___ Laying ___ Other Relief _____

Do you have any other conditions or symptoms that may be related to your current symptoms? Y ___ N ___
If yes, what?_____
Have you ever been in an auto accident or experienced other physical trauma? Y ___ N ___
If yes, please fill in details: Past year ___ 1-5 years ___ 5+ years ____
Describe: _____
Does your pain radiate from a primary area? Y ___ N ___ If yes, where? _____
Do you experience numbness and tingling anywhere? Y ___ N ___ If yes, where? _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____

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EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? Y ___ N ___ Who? _____When? _____
Reason for visit(s): _____
How did you respond? _____

Did your previous chiropractor take before and after x-rays? Y ___ N ___
Did you know posture determines your health? Y ___ N ___
Are you aware of any your poor posture habits? Y ___ N ___
Please explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening our whole body). 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 a developing "hump" at the base of our neck? Y ___ N ___

HEALTH LIFESTYLE

Do you exercise? Y ___ N ___ How often? 1x 2x 3x 4x 5x per week. Other: _____

What activities? Running/Walking ___ Weight Training ___ Cycling ___ Yoga/Pilates ___ Other _____

Do you smoke? Y ___ N ___ How much per day? _____

Do you drink alcohol? Y ___ N ___ How much per week? _____

Do you drink coffee? Y ___ N ___ How many cups per 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 vertebra 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 subluxation 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 effects on your overall health. Please check any 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
__ Headaches/Migraines
__ Allergies/Hay Fever
__ Recurrent Colds/Flu
__ Pain into Your Shoulders/Arms/Hands
__ Thyroid Conditions
__ Sinusitis
__ Hearing Disturbances
__ Weakness in Grip
__ TMJ/Pain/Clicking
__ Dizziness
__ Visual Disturbances
__ Coldness in Hands
__ Numbness/Tingling in Arms/Hands
__ General Fatigue
__ Insomnia
__ Low Metabolism

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 Palpitation
__ Tachycardia
__ Recurrent Lung Infections/Bronchitis
__ Heart Murmurs
__ Shortness of Breath
__ Asthma/Wheezing
__ Heart Attacks/Angina
__ Pain on Deep Inhalation/Exhalation

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THORACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting from 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 in Ribs/Chest
__ Acid Reflux
__ Nausea
__ Ulcers/Gastritis
__ Tired/Irritable after Eating or When You Haven't Eaten
__ Indigestion/Heartburn
__ Hypoglycemia

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.

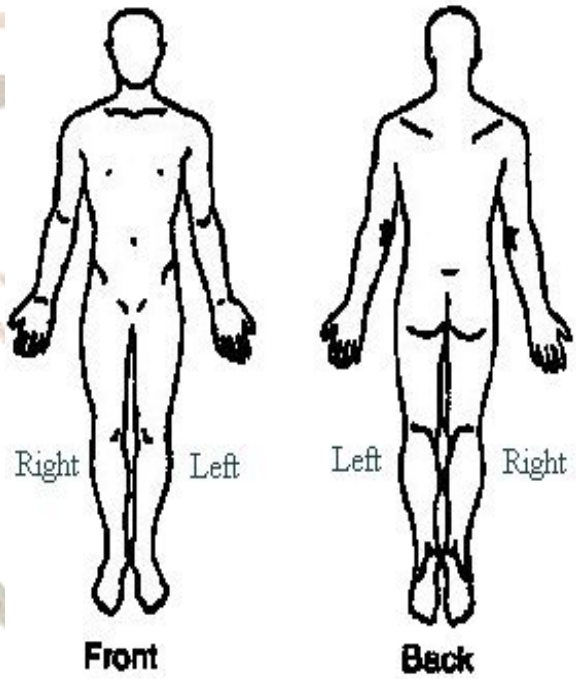
Do you experience:

__ Pain in 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/Injures in Your Hips/Knees/Ankles
__ Recurrent Bladder Infection
__ Frequent/Difficulty Urinating
__ Menstrual Irregularities/Cramping (female)
__ Sexual Dysfunction

Please list any health conditions not mentioned:_____

MEDICAL HISTORY

__Facial Pain
__Headache
__Blurred Vision
__Dizziness
__Earache
__Eye Pain
__Forgetfulness
__Confusion
__Sinusitis
__Teeth Grinding
__Elbow/Hand Pain
__Neck Pain
__Sore Throat
__Lump in Throat
__Swallowing Pain
__Shoulder Pain
__Slow Heart Rate
__Rapid Heart Rate
__Swollen Ankles
__Surgically Implanted Device/Pacemaker
__Low Blood Pressure
__High Blood Pressure
__Abdominal Pain
__Nausea/Vomiting
__Poor Appetite
__Fullness of Bladder
__Urination Difficulty
__Frequent Urination
__Constipation
__Hemorrhoids
__Decreased Sex Drive
__Menstrual Irregularities
__Fatigue
__Tingling in Hands
__Clammy Hands
__Low Back Pain
__Hip Pain
__Knee Pain
__Poor Circulation
__Swollen Joint(s)
__Joint Stiffness
__Walking Problems
__Tingling in Feet
__Sore Muscle
__Weak Muscle
__Paralysis
__Shakiness
__Sweating
__Insomnia
__Fainting
__Convulsions
__Irritability
__Cancer
__Colitis
__Varicose Vein
__Kidney Disease
__Diabetes
__Thyroid
__Seizures(Epilepsy)
__Ankle/Foot Pain



Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing: III Tingling: *** Burning: XXX Numbness: --- Dull: ### Cramping: ^^^

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ALLERGIES
Please check and list all that apply:

□ Food: _____
□ Medications:_____
□ Seasonal: _____
□ Others:_____

MEDICATIONS
Please list all medications you are taking, their intended purpose and the date you began taking them:

_____
_____
_____

SCARS/SURGICAL PROCEDURES
Please list all:

_____
_____
_____

MISCELLANEOUS & HABITS

Are you? Left handed __ Right handed __ Ambidextrous __

Exercise? __ Light __ Moderate __ Heavy __ Type: _____ Frequency: _____

Approximately how many hours do you sleep per night? _____

How many meals per day do you eat? _____ How much water per day do you drink? _____

Alcohol consumption: Light ___ Moderate ___ Heavy ___ None ___

Soda, Diet Soda: Light ___ Moderate ___ Heavy ___ None ___

Tobacco: Light ___ Moderate ___ Heavy ___ None ___

Stress Level: Light ___ Moderate ___ Heavy ___ None ___

Work Activity: Heavy Labor __ Light Labor __ Mostly Standing __ Walking /Moving __ Driving __

Uninterrupted Sleep: Y ___ N ___ Do you feel rested upon waking? Y ___ N ___ Vivid Dreams? Y ___ N ___

How many bowel movements do you have each day? _____

Personal & Family History: Identify conditions that you or any of your family members have now or have previously had. (G=Grandparents, M=Mother, F= Father, S=Sibling, X=Self)

___ Allergies	___ Eczema	___ Miscarriage(S)	___ Tumor(s)
___ Alcoholism	___ Emphysema	___ Mumps	___ Ulcer
___ Anemia	___ Epilepsy	___ Pleurisy	___ Overweight
___ Cancer	___ Goiter	___ Pneumonia	___ Addiction
___ Deep Vein Thrombosis	___ Gout	___ Polio	___ Headaches
___ Detached Retina	___ Heart Disease	___ Rheumatic Fever	___Female Organ Disease
___ Diabetes	___ HIV/AIDS	___ Stroke	

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INFORMED CONSENT TO CHIROPRACTIC, ACUPUNCTURE & MASSAGE CARE

Chiropractic Adjustment: The doctor will use his/her hands or a mechanical device in order to adjust your spinal joint. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a "click" or "pop" as well as a movement of the joint. Various ancillary procedures such as support pillows, traction or hot/cold packs may also be used.

Risk: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days after treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Acupuncture: The provider will use procedures including but not limited to acupuncture, moxabustion, cupping, electro acupuncture, herbology and modes of physiotherapy.

Risks: Risks include but are not limited to slight bruising, tingling near the needling sites that may last a few days, nauseas, infection and blisters. There have been reported instances of fanning, scarring, spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy.

Massage: The provider will perform soft tissue or muscle work using his/her hands.

Risks: Risks may include muscle weakness, muscle and joint soreness, ligament strain, muscular strain.

Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been described as "rare". The risk of cerebrovascular injury or stroke has been estimated at one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be "rare".

Other Treatment Options Which Could be Considered May Include:
Over the counter analgesics may cause irritation to the stomach, liver and kidneys, and other side effects in 1,000 to 4,000 people per one million, and reportedly 16,500 die annually from their use.

Medical care typically includes anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization and bed rest, in conjunction with medical care adds risks of exposure to virulent communicable disease, loss of muscle tone and strength at the rate of 4% per day.

Surgery, in conjunction with medical care adds the risks of infections, adverse reaction to anesthesia, disfiguring scar as well as an extended convalescent period in a significant number of cases. Serious neurological complications from neck surgery are 15,600 per million, mortality rates are 6,900 per million.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative charges. These changes can further reduce skeletal mobility and induce chronic pain cycle. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following risks of my case explained to me. If you and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and authorization for us to submit claims to insurance companies (if applicable). The patient or guardian understands that he/she is responsible for payment of all services.

I have read or have read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

_____	_____	_____
Patient/Guardian - print name	Signature	Date