PATIENT APPLICATION FORM

Welcome to our Clinic! We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is unique and advanced from other rehabilitative programs. 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 decide 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!

Patient Signature

Date

PATIENT APPLICATION SURVEY

Name: _____ Age: _____ M/F: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Social Security #: _____ Driver's License # _____
Birthday: _____ Marital Status: _____# of Children _____
Names of Children: _____ Ages: _____
Do you notice poor postural habits in your Children? Yes _____ No_____
Explain: _____
How were you referred to this office? _____
Employer: _____Type of work: _____
Work Address: _____ Works Phone: _____

PURPOSE OF THIS VISIT

Reason for this visit: _____
Is this purpose related to an auto accident/work injury? Yes _____ No _____
When did this condition begin/when did you first notice it? _____
Describe: _____
Have you experienced this condition before? Yes _____ No _____
Who have you seen for this? _____
How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes_____ No _____ Who: _____
Reason for visits: _____
How did you respond? _____
You know your posture determines your health? Yes_____ No _____
Are you aware of any of your poor postural habits? Yes_____ No_____
Explain: _____
Are you aware of any postural 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 adverse effects on your overall health.
Have you ever been told or feel like you carry your head forward? Yes _____ No _____

HEALTH LIFESTYLE

Do you exercise? Yes No How Often? _____
What activities? _____
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)? _____

ACTIVITIES DISCOMFORT SCALE

For each of the following activities, please place a number in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

ACTIVITY	DOESN'T HURT AT ALL RATES 0	MILD PAIN RATES 1-2	TOLERABLE PAIN RATES 3-4	MODERATE PAIN RATES 5-6	SEVERE PAIN RATES 7-8	DISABLING PAIN RATES 9-10
WALKING						
SITTING						
BENDING						
STANDING						
SLEEPING						
LIFTING						
RUNNING OR JOGGING						
CLIMBING STAIRS						
CARRYING						
PUSHING OR PULLING						
DRIVING						
DRESSING						
READING						
WATCHING TV						
HOUSEHOLD CHORES						
GARDENING						
SPORTS						
EMPLOYMENT						

ADDITIONAL COMMENTS:

_____

_____

Patient Name_____ **Patient Signature** _____

Examiner _____ **Date**_____

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name_____

☐ There is a possibility that I may be pregnant at this time.
☐ Yes, I am definitely pregnant.
☐ No, I am definitely not pregnant
☐ I request that x-ray films not be taken because: _____
_____
_____.

Date of last menstrual period: _____.

_____ _____
Patient Signature Date

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The Clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal or full skin evaluation. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Patient's Signature Date

Chiropractic care, like all forms of health care, while offering considerable benefit 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 artery injury that could lead to a stroke.

Prior to receiving chiropractic care, this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies 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 heath 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 examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.
This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

_____ _____

Patient Signature

WICKISER REHAB & WELLNESS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ DOB _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Wickiser Rehab & Wellness.

(Please Initial one of the following options and sign below.**)**

_____ I wish to receive a paper copy of Privacy Notice.

_____I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

AUTORIZATION OF CARE

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

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

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 the 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, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered.

Patient's Signature	Date	Parent/Guardian	Date

IN CASE OF EMERGENCY CALL:

Name_____
Relationship_____
Work Phone_____
Home Phone _____
Cell Phone _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers my claims and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

Patient Signature _____Date _____
Guardian or Spouse's Signature Authorizing Care _____
Name of Insurance Co. _____ Policy # _____
Address _____Phone # _____
Insured's Name _____Insured's SS# _____
Relationship to insured _____Birth Date _____
Employer _____

WHO SHOULD RECEIVE CHARGES ON YOUR ACCOUNT?

Patient Spouse Parent/Gaudian Worker's Comp
Auto Insurance Medicare Personal Health Insurance

HEALTH CONDITIONS

Name:_____ **Date:**_____

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 structures of your spine. The results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortions 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 any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

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

Neck Pain	Headaches	Sinusitis	Pain into your shoulders/arms/hands
Dizziness	Allergies/Hay fever	Hearing disturbance	Numbness/tingling in arms/hands
Visual disturbances	Recurrent colds/flus	Low energy/fatigue	Weakness in grip
Thyroid conditions	TMJ/Pain/Clicking	Coldness in hands	

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 those parts of your body. Do you experience…?

Heart Palpitations	Recurrent lung Infection/bronchitis	Heart Murmurs	Asthma/wheezing
Tachycardia	Pain on deep inspiration/expiration	Heart attacks/Angina	Shortness of breath

THORACIC APINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and digestive tract, and affect these parts of your body. Do you experience…..?

Mid back pain	Pain into your ribs/chest	Indigestion/heartburn
Hypoglycemia	Tired/Irritable after eating or when	You haven't eaten in a while
Reflux	Nausea	Ulcers/Gastritis

THORACIC 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…?

Low Back Pain	Muscle cramps in your legs/feet	Constipation/Diarrhea
Pain into your hips/legs/feet	Weakness/injuries in your hips/knees/ankles	Sexual dysfunction
Numbness/tingling in your legs/feet	Recurrent bladder infections	Menstrual Irregularities/cramping
Coldness in your legs/feet	Frequent/difficulty urinating	

Please list any health conditions not mentioned_____
Please list any medications/surgeries_____
Please list traumas (falls, car accidents, ect.) _____