111 Crossings West Drive, Unit 5
Lake Ozark, MO 65049
573 693-9452
www.SpinalRejuv.com

Patient Name (Please Print)

PATIENT APPLICATION FORM

Welcome to our clinic! We specialize in helping our patients achieve their highest level of health through corrective care programs. Our techniques correct the condition and posture of the spine as well as associated musculoskeletal conditions that also affect quality of life. Our unique approach offers advances beyond other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Although we focus on corrective care programs, we realize that your condition and circumstance are unique. We value and trust your decisions regarding the care you seek. We are committed and concerned about your health and would like to know your expectations regarding care.

Please check the box that best describes the type of care you are looking for at this time.

- ☐ I am only interested in a health consultation in order to find out whether rehabilitative care may help; I do not want care for my condition at this time.
- ☐ I am only interested in symptomatic care and pain relief.
- ☐ I am interested in corrective care as a long-term solution to my health problems.

Please fill out the following questionnaire accurately and completely so that the doctor can thoroughly evaluate your case. The doctor will use this information you provide as well as your examination and x-rays (if required) to determine whether you are a candidate for our rehabilitative programs. Please feel free to ask questions if you need assistance. We look forward to serving you!

_____ ___/___/___ ___/___/___
Patient Signature DOB: Date

CONFIDENTIAL PATIENT INFORMATION
111 Crossings W Dr. Unit 5, Lake Ozark, MO 65049 / 573 693-9452

PATIENT APPLICATION SURVEY

Patient Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

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

Email Address: _____ Cell Phone: ( ) _____

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

Employer Name: _____ Occupation: _____

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

Spouse's Employer: _____ Occupation: _____

Names of Children: _____ Ages: _____

How were you referred to this office? _____

Do you have health insurance? □ Yes □ No Type of Insurance: □ Commercial / Private □ Medicare □ Medicaid

Primary Insurance Company: _____ Policy ID: _____Group #: _____

Primary Insured / Party Responsible for Billing **(**complete this section **only** if this is ***not*** the patient**):**

Patient's Relationship to Primary Insured / Party Responsible for Billing: □ Self □ Spouse □ Dependent □ Other: _____

Insured's Name: _____

Insured's Birth Date: _____ / _____ / _____ Age: _____ Gender: M F Marital Status: S M D W

Insured's Social Security #: ___ _____ - _____ - _____

Insured's Address: _____ Insured's Home Phone: ( ) _____

City, State, Zip: _____ Insured's Work Phone: ( ) _____

Email Address: _____ Insured's Cell Phone: ( ) _____

Employer Name: _____Occupation: _____

Secondary Insurance Company: _____ Policy ID: _____Group #: _____

(Please allow our staff to photocopy your driver's license and all insurance cards.)

AUTHORIZATIONS:

A. I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or not covered. I understand I am responsible for all copayments, deductibles and non-covered services. I agree to pay all co-pays and fees for non-covered services at the time of service. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

B. I (we) authorize the doctor and staff to release any information deemed appropriate concerning my physical condition to an insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release the doctor and staff of any consequences thereof.

C. I (we) hereby authorize and direct payment from third parties for any medical / chiropractic benefits allowable to the doctor / this office as payment toward the total charges for professional services rendered to be paid directly to the doctor / this office. This payment will not exceed my indebtedness to the assignee.

D. I (we) authorize this office to maintain a photocopy of my driver's license and all available insurance cards. I agree to notify this office immediately when my insurance provider (or plan) changes and to provide the new insurance card for the records. I agree that a photocopy of this agreement shall serve as the original.

My Preferred Payment Option(s) (please indicate): □ Cash □ Check □ Visa □ MasterCard □ American Express

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Name: _____ (please print)

CONFIDENTIAL PATIENT INFORMATION
111 Crossings W Dr. Unit 5, Lake Ozark, MO 65049 / 573 693-9452

PURPOSE OF THIS VISIT

Reason for this visit / main complaint(s):_____

_____

_____

When did this condition or set of symptoms begin? _____/_____/_____

How did it begin? □ gradually □ suddenly □ intermittently (coming & going) □ unknown

Is this complaint related to a trauma or injury? □ Yes □ No If so, when did the trauma or injury occur? _____/_____/_____

Type of trauma: □ auto accident □ work injury □ fall □ sports injury □ other: _____

Have you experienced this condition before? □ Yes □ No If so, when? _____/_____/_____ Please describe that past event:

_____

Has this condition become worse recently? □ Yes □ No If so, how has it worsened? □ gradually □ suddenly □ erratically

If not, has the condition: □ remained the same □ improved somewhat

What activities aggravate the condition / symptoms? _____

Is there anything that tends to relieve the symptoms? □ Yes □ No If so, describe: _____

If not, describe what you tried that doesn't help: _____

Type(s) of discomfort (mark all that apply): □ numb □ sharp □ dull □ aching □ burning □ spasms □ throbbing □ tingling □ shooting

Please rate your *overall* level of pain now: 0 1 2 3 4 5 6 7 8 9 10

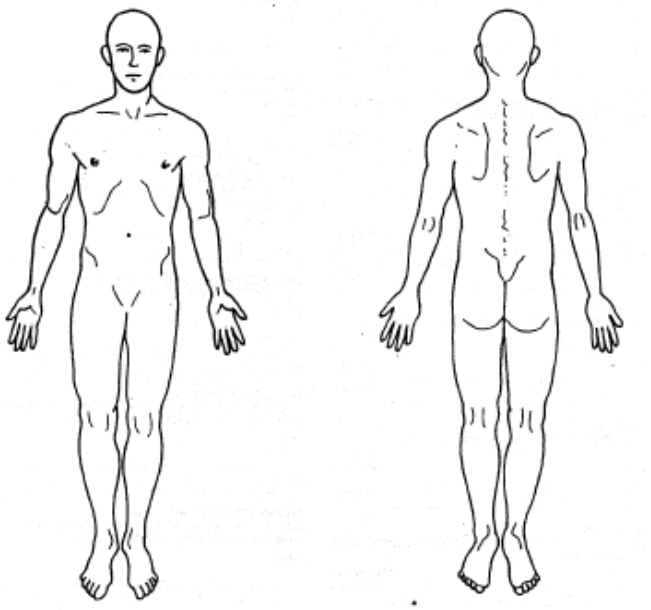
0 = no pain 10 = ready to go to the ER / worst pain ever

Does the pain radiate or travel into your: □ head or face □ arm □ leg □ does not radiate or travel

Describe your pain today:

Circle and number on the diagram each part of the body where you are experiencing significant symptoms. Then use the numbered lines below to make notes about each area.

Use this section to show how your symptoms differ in specific areas. (For example, you might have sharp, radiating pains of strength 6 in one area, while you have dull aching and throbbing discomfort of strength 3 in another place.)



1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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_____

_____

Patient Name: _____ DOB: ___/___/___ Initials: _____ Date: ___/___/___

PURPOSE OF THIS VISIT continued

How often are you affected by your complaint(s)? □ daily □ 4-6 days per week □ 2-3 days per week □ about one day per week

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

Are your symptoms *worse*: □ in the morning □ in the afternoon □ in the evening □ unchanged throughout the day □ other: _____

Are your symptoms *better*: □ in the morning □ in the afternoon □ in the evening □ unchanged throughout the day □ other: _____

Does complaint(s) interfere with: □ work □ sleep □ hobbies □ daily routine Explain: _____

_____

Who have you seen for this? _____ What treatment was tried? _____

How did you respond? _____

Have you had any changes in bodily functions since the condition began? □ Yes □ No

□ balance	□ bowel habits	□ breathing	□ vision	□ weakness	□ grip strength
□ coordination	□ urination	□ coughing	□ hearing	□ fatigue	□ weight loss
□ gait	□ menstrual	□ sneezing	□ sexual function	□ temperature	□ weight gain

Are you currently under medical care for today's main complaint(s) or for any other health condition(s)? □ Yes □ No If so, please explain:

_____

_____

Do you have a pacemaker or any other surgically implanted devices? □ Yes □ No

Describe any other complaints or concerns you have about your health at this time: _____

_____

_____

_____

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EXPERIENCE WITH CHIROPRACTIC

Have you ever received chiropractic care before? □ Yes □ No If so, with whom? _____

Reason for visits: _____ Did your previous chiropractor take before and after x-rays? □ Yes □ No

How frequent were your visits? _____ How did you respond? _____

For how long did you receive care? _____ Date of last visit _____

Were you pleased with the care? □ Yes □ No Reason for ending care: _____

Are you aware that posture is an important determinant of one's overall health and conveys valuable health information? □ 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: _____

Have you noticed (or been told) that you carry your head forward, that your shoulders are rounded, or that you are developing a "hump" at the base of your neck? □ Yes □ No If so, when? _____

Patient Name: _____ DOB: ___/___/___ Initials: _____ Date: ___/___/___

HEALTH LIFESTYLE

In general, how would you describe your health at present? □ excellent □ very good □ good □ fair □ poor

How does your health at present compare to your health one year ago?

☐ much better now than one year ago ☐ about the same ☐ somewhat worse than one year ago
☐ somewhat better now than one year ago ☐ much worse than one year age

Where do you consider your health? □ highest priority □ high priority □ average priority □ low priority □ haven't thought about it

Do you consciously exercise, eat nutritious meals, minimize stress and do things to maintain good health or improve your health? □ Yes □ No

Do you adhere to any particular nutrition plan? If so, describe it: _____

Do you exercise? □ Yes □ No How often? 1X 2X 3X 4X 5X per week What are your typical exercise activities?

□ walking □ jogging □ weight training □ cycling □ yoga □ Pilates □ swimming □ other: _____

List your current height and weight: Ht: _____ Wt: _____

Do you smoke? □ Yes □ No How much? □ 1-5 cig/day □ 6-10 cig/day □ 1 pack/day □ > 1 pack/day: _____

Do you drink alcohol? □ Yes □ No How many drinks per week? _____

Do you drink coffee or other caffeinated drinks? □ Yes □ No How many servings per day? _____

Do you currently have a drug or substance abuse problem? □ Yes □ No If yes, discuss this with the doctor.

List any prescription or non-prescription drugs or supplements (i.e. vitamins, minerals, herbs) you currently take:

Name	Reason for taking	Name	Reason for taking

FAMILY MEDICAL HISTORY

Indicate your living family members and the medical conditions experienced by your family members (living or deceased).

condition	mother	father	grandparents maternal / paternal		siblings (how many?)
mark family members currently living					
1. high blood pressure					
2. cardiovascular disease					
3. diabetes					
4. arthritis					
5. cancer					
6. stroke					
7. back or neck pain					
8. other:					
9. other:					

additional information: _____

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Patient Name: _____ DOB: ___/___/___ Initials: _____ Date: ___/___/___

MEDICAL HISTORY

CURRENT CONDITIONS

1. Do you have skin, hair or nail problems? □ Yes □ No _____
2. Do you have mouth and / or throat problems? □ Yes □ No _____
3. Do you have nose and / or sinus problems? □ Yes □ No _____
4. Do you have ear problems? □ Yes □ No _____
5. Do you have eye problems? □ Yes □ No _____
6. Do you have chest or lung (breathing) problems? □ Yes □ No _____
7. Do you have heart and / or blood vessel problems? □ Yes □ No _____
8. Do you have blood or lymph node problems? □ Yes □ No _____
9. Do you have digestive problems? □ Yes □ No _____
10. Do you have urinary (including kidney or bladder) problems? □ Yes □ No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal, uterus)? □ Yes □ No _____
12. Females: Do you have menstrual problems? □ Yes □ No _____
    Have you ever taken birth control pills? □ Yes □ No Are you currently taking them? □ Yes □ No How long? _____
    Is it possible that you are currently pregnant? □ Yes □ No If you are pregnant, what is your due date? _____
    Are you currently nursing? □ Yes □ No Do you have any breast problems? □ Yes □ No _____
13. Do you have any gland and / or hormone problems? □ Yes □ No _____
14. Do you have any allergy or immunity problems? □ Yes □ No _____
15. Do you have any nervous system diseases and / or mental health problems? □ Yes □ No _____
    _____
16. Do you have any muscle, tendon or ligament problems? □ Yes □ No _____
17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? □ Yes □ No _____
    _____

PAST CONDITIONS

18. List any diseases that you have had in the past, including childhood diseases: _____
    _____
19. Have you ever been diagnosed with or told by another medical doctor that you have a particular condition, such as diabetes, cancer, AIDS, cardiovascular disease, etc.: _____
    _____
20. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head trauma, strains, lacerations, sprains, dislocations, broken or cracked bones? □ Yes □ No Please describe: _____
    _____
21. List any surgeries or operations you have had (including appendectomy, tonsillectomy, ear tubes, vasectomy, and hysterectomy):
    1. _____ date:_____
    2._____ date:_____
    3._____ date:_____
    4._____ date:_____
    5._____ date:_____

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Patient Name: _____ DOB: ___/___/___ Initials: _____ Date: ___/___/___

HEALTH CONDITIONS, continued

Abnormal postural habits or distortions result from trauma, stress, unbalanced muscles, and the affect of gravity on the body. When your spine becomes unbalanced and misaligned from its normal position, this causes stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments, called subluxations, can result in a broad range of the symptoms below, which makes the following survey of your symptoms helpful in diagnosing misalignments.

Please check any health condition you have experienced in the past ("P") or experience currently ("C") or both.

CERVICAL SPINE (NECK):

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

□ C □ P neck pain	□ C □ P eye redness or discharge	□ C □ P loss of smell
□ C □ P neck stiffness	□ C □ P dry eyes	□ C □ P allergies / hay fever
□ C □ P neck lump or mass	□ C □ P light-headedness	□ C □ P nasal discharge
□ C □ P headaches: stress	□ C □ P loss of balance	□ C □ P recurrent colds / flu
□ C □ P headaches: migraine	□ C □ P spinning sensation / vertigo	□ C □ P low energy / fatigue
□ C □ P pain in shoulders / arms / hands	□ C □ P ear pain	□ C □ P TMJ / jaw pain / clicking
□ C □ P numbness or tingling in arms / hands	□ C □ P ringing in ears	□ C □ P bad breath
□ C □ P weakness in grip	□ C □ P hearing loss or disturbance	□ C □ P loss of taste
□ C □ P coldness in hands	□ C □ P ear discharge	□ C □ P loss of touch sensation
□ C □ P eye pain	□ C □ P thyroid conditions	□ C □ P stroke or TIA
□ C □ P visual disturbances	□ C □ P sinusitis	

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back can weaken the nerves to the heart and lungs, affecting these parts of your body. Do you experience…?

□ C □ P chest pain	□ C □ P fatigue	□ C □ P shortness of breath
□ C □ P heart palpitations	□ C □ P swelling in the legs	□ C □ P pain on deep inspiration / expiration
□ C □ P heart murmurs	□ C □ P changes in skin color	□ C □ P frequent / chronic cough
□ C □ P tachycardia	□ C □ P heart valve problems	□ C □ P phlegm
□ C □ P heart attacks / angina	□ C □ P recurrent lung infections / bronchitis	□ C □ P coughing up blood
□ C □ P fainting	□ C □ P asthma / wheezing	□ C □ P blue skin (cyanosis)

THORACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back can weaken the nerves spreading throughout your ribs and chest, as well as your urinary and upper digestive tracts, affecting these parts of your body. Do you experience…?

□ C □ P mid back pain	□ C □ P reflux	□ C □ P bloating, abdominal distention
□ C □ P pain in your ribs / chest	□ C □ P nausea	□ C □ P hypoglycemia
□ C □ P abdominal pain	□ C □ P ulcers / gastritis	□ C □ P tired or irritable after eating *or* when you haven't eaten for a while
□ C □ P indigestion / heartburn	□ C □ P cramping	

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs and feet, lower digestive tract, and urinary and pelvic organs, affecting these parts of your body. Do you experience…?

□ C □ P low back pain		□ C □ P constipation	□ C □ P change in urine color
□ C □ P pain in your hips, legs, or feet	□ C □ P	diarrhea	□ C □ P kidney stones
□ C □ P numbness or tingling in your legs or feet	□ C □ P	pain during urination	□ C □ P menstrual irregularities or cramping
□ C □ P coldness in your legs or feet	□ C □ P	recurrent bladder infections	□ C □ P sexual dysfunction
□ C □ P muscle cramps in your legs or feet	□ C □ P	change in frequency of urination	□ C □ P genital itching
□ C □ P weakness or injuries in your hips, knees, or ankles	□ C □ P	change in urine flow	□ C □ P rectal bleedin

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Patient Name: _____ DOB: ___/___/___ Initials: _____ Date: ___/___/___