Functional
WELLNESS CENTER

PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through our spinal and postural corrective programs. Our approach is very 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 let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____

PATIENT APPLICATION SURVEY

Full Name_____ Today's Date _____

Date of Birth_____Age_____ Gender F M Marital Status S M W D

Email_____ Height _____ Weight _____

Address_____ City_____Zip_____

Home Phone_____ Cell Phone _____

Occupation_____ Employer Name _____

Emergency Contact_____ Emergency Phone _____

Preferred Language_____ Race _____ Ethnicity _____

Who Should We Thank for Referring You to Functional Wellness Center? _____

PURPOSE OF THIS VISIT

Health Issue	Date Condition Started	Frequency	Severity (0-10)
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____

Are these conditions getting worse? ❑ Yes ❑ No 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? ❑ Yes ❑ No

❑ Ice ❑ Heat ❑ Massage ❑ Resting ❑ Exercise ❑ Sitting ❑ Standing

❑ Bracing/Taping ❑ Stretching ❑ 'Popping' Joints ❑ Laying ❑ Other _____

PURPOSE OF THIS VISIT (continued)

Does your pain radiate from the primary area? ❑ Yes ❑ No If yes, where ? _____

Do you experience numbness and tingling anywhere? ❑ Yes ❑ No If yes, where? _____

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? _____

Reason 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

Please Explain:

Are you aware of poor posture habits in your spouse or children? ❑ Yes ❑ No

Please 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 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 your neck? ❑ Yes ❑ No

HEALTH LIFESTYLE

Do you exercise? ❑ Yes ❑ No How often? 1x 2x 3x 4x 5x per week Other: _____

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

Do you smoke? ❑ Yes ❑ No How much? _____ Former Smoker? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How much/week? _____

Do you drink coffee? Yes ❑ 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 effects 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 any health condition you may be experiencing, now or in the past.

HEALTH LIFESTYLE (continued)

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
- ❑ Thyroid Conditions
- ❑ TMJ/Pain/Clicking
- ❑ General Fatigue
- ❑ Headaches/Migraines
- ❑ Sinusitis
- ❑ Dizziness
- ❑ Insomnia
- ❑ Allergies/hay fever
- ❑ Hearing disturbances
- ❑ Visual disturbances
- ❑ Low Metabolism
- ❑ Skin Issues-Acne/dryness
- ❑ Depression/anxiety
- ❑ Difficulty focusing/ ADHD
- ❑ Difficulty losing weight
- ❑ Recurrent colds/flu
- ❑ Weakness in grip
- ❑ Coldness/sweating in hands
- ❑ Brain Fog/ difficulty focusing
- ❑ Pain into your shoulders /arms/hands
- ❑ Numbness/tingling in arms/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 these parts of your body. Do you experience:

- ❑ Heart palpitation
- ❑ Heart murmurs
- ❑ Asthma/ wheezing
- ❑ Tachycardia
- ❑ Shortness of breath
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Pain on deep inhalation / exhalation

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
- ❑ Nausea
- ❑ Indigestion/heartburn
- ❑ Pain into your ribs/chest
- ❑ Ulcers/gastritis
- ❑ Hypoglycemia
- ❑ Acid reflux
- ❑ Tired/irritable after eating or when you haven't eaten

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
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Numbness/tingling in your legs/feet
- ❑ Recurrent bladder infection
- ❑ Coldness in your legs/feet
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in your legs/feet
- ❑ Menstrual irregularities/cramping (females)
- ❑ Constipation/diarrhea/gassiness/ bloating
- ❑ Sexual dysfunction
- ❑ Low back pain

*What is your commitment level for **<u>correcting any spinal concerns</u>** we may find? On a scale from 0-10, with 10 being the highest level of commitment_____*

Please list any health conditions not mentioned: _____

Please list any medication/surgeries: _____

MEDICAL HISTORY

Do you or any one in your family been diagnosed with any of the following:

❑ Diabetes	❑ Varicose Veins	❑ Neurological Problems	❑ Lung Disease
❑ Rheumatic Fever	❑ Circulatory Problems	❑ Stroke	❑ Heart Murmurs
❑ High Blood Pressure	❑ Heart Disease	❑ Cancer	❑ Osteoporosis
❑ Kidney Disease	❑ Seizures	❑ Migraine	❑ Headaches
❑ Liver Disease	❑ Metal Implants	❑ Infectious Disease	❑ Gallbladder
❑ Broken Bones/Fractures	❑ Appendectomy	❑ Tonsillectomy	❑ Hernia
❑ Pneumonia	❑ Polio	❑ Tuberculosis	❑ Anemia
❑ Whooping Cough	❑ Chicken pox	❑ Mumps	❑ Measles
❑ Thyroid	❑ Small Pox	❑ Influenza	❑ Pleurisy
❑ Arthritis	❑ Epilepsy	❑ Difficulty Urinating	❑ Eczema
❑ Gout	❑ Prostate	❑ Glaucoma	❑ AIDS

Current Medications:

Over the counter medication (please list) _____

Prescription medication (please list) _____

Others/supplements (please list) _____

Please list any medication you are allergic to _____

Please list any allergies and reactions: (include dietary allergies) _____

Previous surgeries (all type)	Approximate date
1. _____	_____
2. _____	_____
3. _____	_____

PRIMARY CARE PHYSICIAN INFORMATION

Doctor's Name _____ Specialty _____

Address _____ City _____ Zip _____

Telephone _____ Last Date of Visit _____

In order to provide complete and wholesome care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize Functional Wellness Center to contact your physician, request medical records, and/or co-manage your healthcare needs.

_____

Patient's Name (Please Print) Date Patients Signature

_____

Minor's Name (Please Print) Date Guardian's Signature

Pain Dysfunction Questionaire (Spine 2004) BE SURE TO ANSWER ALL QUESTIONS.

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by **MAKING AN "X" ALONG THE LINE** to rate how much your pain problem has affected you from 0 to 10 (from having no problems at all to having the most severe problems you can imagine).

0 1 2 3 4 5 6 7 8 9 10

F1. Does your pain interfere with your normal work inside and outside the home?
]_____]_____]_____]_____]_____]_____]
Work Normally — Unable to work at all

F2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
]_____]_____]_____]_____]_____]_____]
Take care of myself completely — Need help with personal care

F3. Does your pain interfere with your traveling?
]_____]_____]_____]_____]_____]_____]
Travel anywhere I like — Only travel to see doctors

F4. Does your pain affect your ability to sit or stand?
]_____]_____]_____]_____]_____]_____]
No problems — Cannot sit/stand at all

F5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
]_____]_____]_____]_____]_____]_____]
No problems — Cannot do at all

F6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
]_____]_____]_____]_____]_____]_____]
No problems — Cannot do at all

F7. Does your pain affect your ability to walk or run?
]_____]_____]_____]_____]_____]_____]
No problems — Cannot walk/run at all

P8. Has your income declined since your pain began?
]_____]_____]_____]_____]_____]_____]
No decline — Lost all income

P9. Do you have to take pain medication every day to control your pain?
]_____]_____]_____]_____]_____]_____]
No medication needed — On pain medication throughout the day

P10. Does your pain force you to see doctors much more often than before your pain began?
]_____]_____]_____]_____]_____]_____]
Never see doctors — See doctors weekly

P11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
]_____]_____]_____]_____]_____]_____]
No problem — Never see them

F12. Does your pain interfere with recreational activities and hobbies that important to you?
]_____]_____]_____]_____]_____]_____]
No interference — Total interference

F13. Do you need the help of your family and friends to complete everyday tasks (both housework and outside work) because of your pain?
]_____]_____]_____]_____]_____]_____]
Never need help — Need help all the time

P14. Do you now feel more depressed, tense, or anxious than before your pain began?
]_____]_____]_____]_____]_____]_____]
No depression/tension — Severe depression/tension

P15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
]_____]_____]_____]_____]_____]_____]
No problems — Severe problems

FSC_____ PC_____ Total_____

AUTHORIZATION & PRIVACY

AUTHORIZATION CARE

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments, CBP® rehabilitation techniques, 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 this clinic. I also clearly understand that if I do not follow the doctor's 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 Name (Please Print)	Date	Patients Signature
Minor's Name (Please Print)	Date	Guardian's Signature

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES FUNCTIONAL WELLNESS CENTER TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Functional Wellness Center to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings. I give permission to Functional Wellness Center to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Functional Wellness Center permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

I,_____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent
The right to object to the use of my health care information for directory purpose
The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operation.

Patient Name	Patient Signature	Date
Doctor's Name	Doctor's Signature	Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND FINANCIAL AGREEMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below), for whom I am legally responsible by the doctor or intern affiliated with Functional Wellness Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

Financial Agreement: I agree that in return for the services provided to me by the Functional Wellness Center I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Functional Wellness Center for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy insuring the patient or any other party liable to the patient is hereby assigned to the Functional Wellness Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Functional Wellness Center accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a scheduled appointment at Functional Wellness Center, I may be charged a cancellation fee which is at the discretion of Functional Wellness Center.

Assignment of Benefits: I agree that payments intended for the Functional Wellness Center in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to the Functional Wellness Center.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Functional Wellness Center to perform such. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient's Signature

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www.functionalwellnessaz.com