Destiny CHIROPRACTIC

Name:_________________________ D.O.B.____________ Acct #:________

NEW PATIENT APPLICATION FOR CARE 1/5

Welcome to our Practice! Please thoroughly complete all questions, printing clearly and allow our staff to photocopy your driver's license and insurance card.

Today's Date:________________

Name you prefer to be addressed by _______________________

Address: ____ City/State/Zip: _____________________________________

Race: American Indian or Alaska native / Asian / Black or African American / White or Caucasian / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer   Preferred language: ___________________

Marital status: M/W/D/S   Gender: M / F   Gender at birth: M / F

Ever smoked: Y / N How long? ___________ How much? ____________ If quit, date quit ___/____/____

Phone: Cell: ____________________ Home _____________________ E-Mail: _________________________________

Preferred method of contact: ______________Birthdate:___/____/____ Age:_____ Social Security #:_____-____-_____

Who may we thank for referring you? ____

Your prior Doctor of Chiropractic and address: ____

Chiropractic techniques you've had success with: ____

Last time you went to previous Doctor of Chiropractic ____

General Practitioner, phone, city & state: _____________________________/ ________________/_________________

Please rate on a scale of 1 (poor) – 10 (excellent) the quality of healthcare you feel you receive from your GP: _________

Other specialists you are currently under care with:

Name: ____ Phone: ___________________________

Name: ____ Phone: ___________________________

Name: ____ Phone: ___________________________

Occupation: ____ May we contact you at work ___ Y ___ N

Your employer, address and phone number: _________________/______________________________/_____________

Spouse's name: ____ Date of Birth ____/____/_______

Spouse's employer: ____________________________________ Children's names & ages: _______________ (_______)
_____________________ (_______)   _____________________ (_______)   _____________________ (_______)

Favorite hobbies or interests: ____

Method of payment for first visit: _____ Cash _____ Check _____ Credit Card

Date of last menstrual cycle: _____ / _____ / ________

What do you understand chiropractic care to be? ____

____

Do you know what a subluxation is? Y / N if so, describe: ____

What daily rituals for spinal health do you presently practice? ____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____________

Do you have health (crisis care) insurance? ___ Y ___ N

Destiny CHIROPRACTIC

Name:____________________________ **D.O.B.**_______________ **Acct #:**_________

NEW PATIENT APPLICATION FOR CARE 2/5

Primary Complaint (P)

The primary symptom that prompted me to seek care today is:

____

____

And are caused by: (darken circle)

- ○ An accident or injury
  - ○ Work ○ Auto ○ Other: ____________

____

- ○ A worsening long term problem
- ○ An interest in wellness
- ○ Other _____________________________

Onset (When did you first notice your current symptoms?) _____________________________

Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice

Secondary Complaint (S)

The secondary symptom that prompted me to seek care today is:

____

____

And are caused by: (darken circle)

- ○ An accident or injury
  - ○ Work ○ Auto ○ Other: ____________

____

- ○ A worsening long term problem
- ○ An interest in wellness
- ○ Other _____________________________

Onset (When did you first notice your current symptoms?) _____________________________

Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice

Additional Complaint (A)

The additional symptom that prompted me to seek care today is:

____

____

And are caused by: (darken circle)

- ○ An accident or injury
  - ○ Work ○ Auto ○ Other: ____________

____

- ○ A worsening long term problem
- ○ An interest in wellness
- ○ Other _____________________________

Onset (When did you first notice your current symptoms?) _____________________________

Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Acupuncture
- ○ Over-the-counter drugs ○ Chiropractic
- ○ Homeopathic remedies ○ Massage
- ○ Physical therapy ○ Ice

How does your current condition(s) affect…

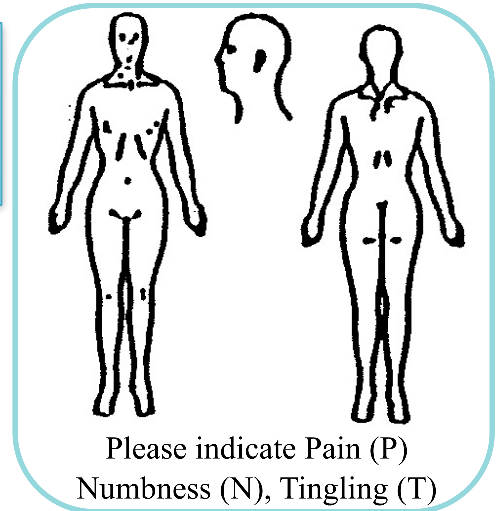
Work/career: ____

Recreational activities: ____

Household responsibilities: ____

0	1-2	3-4	5-6	7-8	9-10
	MILD	MODERATE		SEVERE	
NO PAIN	CAN BE IGNORED	INTERFERES WITH TASKS	INTERFERES WITH CONCENTRATION	INTERFERES WITH BASIC NEEDS	BEDREST REQUIRED

Please rate the intensity of your primary complaint pain above.



Please indicate Pain (P) Numbness (N), Tingling (T)

Have you had same or similar problem(s) before? Y / N How long ago? ____

What else should Dr. Bonner know about your condition? ____

Medication(s) you currently take:

______ Check if NONE

______ CHECK if more on back

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Medication allergies:

______ Check if NONE

______ CHECK if more on back

Allergy to	Reaction	Additional Comments

My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:____ **Date:**____/____/________

Name:___________________________ D.O.B.______________ Acct #:________

PATIENT APPLICATION FOR CARE 3/5

Systems Review

It is important to read the following before filling out this form.

Any and all physical events that our body goes through leaves obvious and in most cases not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions. Even the ones you believe we have already verbally asked you.

1. **Review of Systems**

   (Chiropractic focuses on the integrity of your nervous system which controls and regulates your entire body.

Please circle any condition that you have had or currently have.

Musculoskeletal:
osteoporosis
arthritis
scoliosis
neck trouble
mid back trouble
Low back trouble
hip disorders
knee injuries
foot/ankle
shoulder/elbow/wrist
TMJ
poor posture

Neurological:
anxiety
depression
headache
dizziness
tingling
numbness

Cardiovascular:
high blood pressure
low blood pressure
poor circulation
angina
excessive bruising
high cholesterol

Respiratory:
Asthma
Apnea
Emphysema
hay fever
shortness of breath
pneumonia

Digestive:
anorexia/bulimia
ulceri
food sensitivities
heartburn
constipation/diarrhea

Sensory:
blurred vision
ringing in ears
hearing loss
chronic ear infections
loss of smell
loss of taste

Skin:
skin cancer
psoriasis
eczema
acne
hair loss
rash
tattoo(s)
body piercing(s)

Endocrine :
thyroid issues
immune disorders
hypoglycemia
frequent infections
swollen glands
low energy

Genitourinary:
kidney stones
infertility
bedwetting
prostate issues
erectile dysfunction
PMS symptoms

Constitutional :
fainting
low libido
poor appetite
fatigue
sudden weakness
weight loss/gain

Name:_________________________ D.O.B.______________ Acct #:________

PATIENT APPLICATION FOR CARE 4/5

2. Illnesses

AIDS	HIV positive
Alcoholism	malaria
Allergies	measles
arteriosclerosis	Multiple Sclerosis
cancer	mumps
chicken pox	polio
diabetes	Rheumatic Fever
epilepsy	STD
glaucoma	stroke
goiter	tuberculosis
gout	Typhoid Fever
heart disease	ulcer
hepatitis	other _________________

3. Surgeries

- bypass surgery
- cancer
- cosmetic surgery
- elective surgery ___________
- eye surgery
- hysterectomy
- pacemaker
- spine _____________________
- tonsilectomy
- vasectomy
- other _____________________

4. Treatments

- acupuncture
- acupressure
- antibiotics
- birth control pills
- blood transfusions
- chemotherapy
- chiropractic care
- dialysis
- herbs/homeopathy
- inhaler
- massage therapy
- physical therapy

5. Injuries (have you ever had)

- had a fractured/broken bone
- had a spine or nerve disorder
- been knocked unconscious
- been injured in an accident
- used a crutch or other support
- used neck or back bracing

6. Social History

(Tell Dr. Bonner about your health, hobbies and stress levels)

alcohol use	○ daily	○ weekly	How much? ______________________	Prayer/meditation?	○ yes	○ no
coffee use	○ daily	○ weekly	How much? ______________________	Job pressure/stress?	○ yes	○ no
tobacco use	○ daily	○ weekly	How much? ______________________	financial peace?	○ yes	○ no
exercising	○ daily	○ weekly	How much? ______________________	Vaccinated?	○ yes	○ no
pain relievers	○ daily	○ weekly	How much______________________	mercury fillings?	○ yes	○ no
soft drinks	○ daily	○ weekly	How much? ______________________	recreational drugs?	○ yes	○ no
water intake	○ daily	○ weekly	How much? ______________________			

Hobbies: ____times/week ________ hours/time ________

7. Family History

Age (if living)		State of health		Illnesses	Age at death	Cause of death		
		Good	Poor			Natural	Illness	Injury
Mother	__________	○	○	______________________	__________	○	○	○
Father	__________	○	○	______________________	__________	○	○	○
Sister 1	__________	○	○	______________________	__________	○	○	○
Sister 2	__________	○	○	______________________	__________	○	○	○
Brother 1	__________	○	○	______________________	__________	○	○	○
Brother 2	__________	○	○	______________________	__________	○	○	○
_______	__________	○	○	______________________	__________	○	○	○

______________________________ __________ ______________________________ __________
Patient signature Date Doctor signature Date

Name:____________________________ D.O.B.______________ Acct #:________

AUTHORIZATION - The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints and if Chiropractic can help. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENTS - We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

Also, I acknowledge Chiropractic is a separate and distinct practice from traditional medicine.

Also, I acknowledge that Dr. Bonner will deliver care that, in her professional judgment, can best help me in the restoration of my health. I also acknowledge that the chiropractic care offered in this practice is based on acceptable standards of care designed to reduce or correct vertebral subluxation.

Also, I realize that an x-ray exam may be hazardous to an unborn child and I certify that to the best of my knowledge I am NOT pregnant. Date of last menstrual period ___/___/______

Also, I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

___________________________	___________________________
Patient Name Printed	Date
___________________________	___________________________
Patient Signature	Authorized Provider Rep.
___________________________	___________________________
Personal Representative Printed	Personal Rep. Signature

____

Description of personal representative's authority to act for the patient