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 — NO PAIN

1-2 — MILD — CAN BE IGNORED

3-4 — MODERATE — INTERFERES WITH TASKS

5-6 — MODERATE — INTERFERES WITH CONCENTRATION

7-8 — SEVERE — INTERFERES WITH BASIC NEEDS

9-10 — SEVERE — 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 #:_________

New Patient Application for Pregnant Patient

Date________________________________

Home Telephone______________________Work Telephone______________________

Name of Husband_____________________Husband's Employment_______________________

Insurance Information____

Did a health problem prompt you to visit a chiropractor?_________Explain_____________________________

____

Previous Major Illness or Surgery____

____

Medications you are currently taken or have taken since conception_____________________________

____

Allergies____

Do you smoke? ____________ (If no did you ever smoke)?________ How Long________________

Do you drink? None ________Social (Fewer then 2 daily) ___________Heavy (2 or more daily)_______

List the foods you eat daily and summary of your diet habits ____________________________________

____

What type of exercises do you do? ____

____

Age at last menstrual cycle? ______________Length of regular menstrual cycle? _______________

Are your cycles regular? Always __________Most of the time___________Never _____________

Date of your last menstrual cycle ________________Was it normal? _________________________

Date of last x-rays if any? ________________Why and by whom? ___________________________

Have you had any previous pregnancies? Explain ____

____

Have you had past cesareans?______How many?_________

Have you had a previous D&C?_____How many and dates? _____________

Do you have any of the following?

Diabetes_____Asthma______Rh negative blood__________Other chronic problems___________

Have you taken birth control pills?_________Type_____________________

Have you used an IUD?___________Date of removal__________________

Did you have any health problems during previous pregnancies? Explain _________________________________

____

Have you ever received chiropractic care?_________Dr's. Name___________________________

Results____

Who referred you to our office?____

Name of your obstetrician?_______________Nurse/Midwife?______________________________

Doula/Other______________________Where do you plan to have your baby?________________________

What symptoms of pregnancy have you already experienced?______________________________

Additional comments____

____

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 Good	Poor	Illnesses	Age at death	Cause of death 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