shift health center

Office Use Only
In:____
Out:____
Initial: _____

New Practice Member Application

Name_____ Preferred Name_____ Date of Birth_____ Age_____ ☐Male ☐Female

Address_____ Apt #: _____ City _____ State_____ Zip_____

Phone: Cell_____ Home_____ Email Address_____

Occupation_____ Employer's Name_____

☐ Single ☐Married ☐Divorced ☐Widowed Spouse's Name_____

How did you hear about us? _____

Emergency Contact Name_____ Phone Number_____ Relationship_____

If you have someone who helps you make important health decisions (ie: a spouse, family member, friend, etc.) we encourage you to bring them with you to your first appointment.

REVIEW OF SYMPTOMS

Please Mark "P" For In The Past and Mark "C" For Currently Have:

___ Headaches	___ Allergies	___ Thyroid Issues	___ Sexual Dysfunction	___ Numb/Tingling Arms/Hands (L/R)
___ Migraines	___ Sinus Issues	___ Sinus Issues	___ Infertility	___ Numb/Tingling Legs/Feet (L/R)
___ Jaw/TMJ Pain	___ Ear Infections	___ Digestive Issues	___ Excess Weight	___ Neuropathy Hands/Feet (L/R)
___ Neck Pain	___ Asthma	___ Diarrhea	___ Ringing in the Ears	___ Stroke
___ Shoulder Pain (L/R)	___ Difficulty Breathing	___ Constipation	___ Hearing Loss	___ Heart Attack
___ Elbow/Wrist Pain	___ Loss of Balance	___ Gastric Reflux	___ Seizures	___ Heart Problems
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ High/Low Blood Pressure
___ Mid Back Pain	___ Dizziness	___ Ulcers	___ Tremors	___ Chest Pain
___ Lower Back Pain	___ Loss of Energy	___ Bedwetting	___ Diabetes Type 1	___ Cancer
___ Hip/Leg Pain (L/R)	___ Sleep Problems	___ Bladder Problems	___ Diabetes Type 2	___ Spinal Bone Fracture
___ Sciatic Pain (L/R)	___ Anxiety	___ Kidney Problems	___ Fibromyalgia	___ Spinal Surgery
___ Knee Pain (L/R)	___ Depression	___ Menstrual Problems	___ Poor Posture	___ Disc Problems
___ Foot Pain (L/R)	___ ADD/ADHD	___ Active Cancer	___ Skin Problems	___ Scoliosis
		___ Prostate Problems	___ Arthritis/Joint Pain	

Other Conditions/Diseases:_____

List The Health Problems You Are Most Interested In Getting Corrected:

Health Concern: List according to severity	Rate of Severity 0=No Issues 10=Unbearable	How long have you been suffering from these problems?	Have had the problem before? If so, when?	How many days per week do you experience these problems?
#1: _____	_____	_____	_____	_____
#2: _____	_____	_____	_____	_____
#3: _____	_____	_____	_____	_____

MEDICAL HISTORY

Do you have a pacemaker or other medical device?_____

Have you had a steroid or cortisone injection in the last 30 days?_____

Do you have a history of blood clots?_____

1. List all surgical operations & years:_____
2. List all injuries/falls or auto accidents & years: _____
3. What have you done to try and get your problems corrected? ☐Chiropractic ☐PT ☐Medication

Other:_____

QUALITY OF LIFE

1. What are your symptoms already affecting and/or what are you worried they will affect in the future? Please check ALL that apply:

☐ Sleep	☐ Balance	☐ Work
☐ Climb Stairs	☐ Freedom	☐ Finances
☐ Walking	☐ Self-Esteem	☐ Energy Level
☐ Sitting/Standing	☐ Household Chores	☐ Recreational Activities
☐ Lifting Objects	☐ Relationships	☐ Time
☐ Ability to Drive	☐ Kids	☐ Future Abilities

2. How has your health condition affected the boxes marked above? Please give examples for each:

3. What would be better/different in your daily life without these symptoms? Please be specific:

4. If your symptoms are not treated, are there health conditions you are afraid this might turn into?

☐ Heart Disease	☐ Arthritis	☐ Chronic Fatigue
☐ Cancer	☐ Fibromyalgia	☐ Need Surgery
☐ Diabetes	☐ Depression	☐ Family Health Problems

5. What are you most concerned with regarding your problem?

6. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific:

7. What do you desire most to get from working with us?

8. What would that mean to you?

Quadruple Visual Analogue Scale (QVAS)

Patient's Name_____ Date: _____

Instructions: Please circle the number that best describes the question being asked. *Remember, a low number means there is less pain; a higher number means there is more pain.*

The pain I am rating is: (brief description, 'Back pain," "Neck pain," etc.)

_____

1 - Rate your pain RIGHT NOW

No Pain_____Worst Possible pain
0 1 2 3 4 5 6 7 8 9 10

2 - Rate your TYPICAL OR AVERAGE pain

No Pain_____Worst Possible pain
0 1 2 3 4 5 6 7 8 9 10

3 - Rate your pain AT ITS WORST (how close to a "10" does your pain get?)

No Pain_____Worst Possible pain
0 1 2 3 4 5 6 7 8 9 10

4 - Rate your pain AT ITS BEST (how close to a "0" does your pain get?)

No Pain_____Worst Possible pain
0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OATS
0.0

To calculate Outcome Assessment Tool Score **(*OATS*)**, add first three numbers, divide by 3 and multiply by 10.

INFORMED CONSENT FOR CARE

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

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, this will help us determine if there is any reason to modify your care or provide you with a referral to another health 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 examination and chiropractic care that the doctor deems necessary, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Shift Health Center. I agree that this authorization will cover all services rendered until I revoke the authorization, I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for all charges not covered. In the event of any legal action or proceeding relating to the subject matter of this agreement, the non-prevailing party shall reimburse the prevailing party for all reasonable attorney fees and costs resulting therefrom.

Print Name: _____

Signature: _____ **Date:** _____

If This Health Profile Is for A Minor/Child, Please Fill Out and Sign Below

Written Consent for A Child

Name of Practice Member who is a Minor/Child: _____

I authorize the doctors at Shift Health Center and any/all Shift Health Center staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Shift Health Center.

Guardian Signature: _____ **Date:** _____

Relationship to Minor/Child: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

Release of Information:
[ ] authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name _____ Relationship _____Contact _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays, Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations, The doctors of Shift Health Center do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Full Legal Name: _____ Date of Birth: _____

Signature: _____Date: _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Shift Health Center.

Signature: _____Date: _____