

APPLICATION FOR CARE AT **UPWARD SHIFT CHIROPRACTIC**

Today's Date: _____

HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: ____-____-____ Age: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: Single Married Do you have insurance? Yes No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Primary or chief complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Second complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is:	0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? No Yes **If yes**, when? _____ by whom? _____

How long were you under care? _____ What were the results? _____

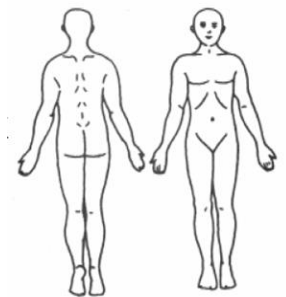
Name of previous chiropractor: _____ N/A

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____



LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
--------------------------	------------------------	----------------------

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Is your problem the result of ANY type of accident? Yes No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? No Yes **If yes**, how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: No Yes **If yes**, please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results. Favorable Unfavorable Please explain: _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the **Past** **C** for **Currently** have **N** for **Never** have had

Broken Bone Dislocations Tumors Rheumatoid Arthritis Fracture Disability Cancer
 Heart Attack Osteo Arthritis Diabetes Cerebral Vascular Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? No Yes **If yes**, whom?
 grandmother grandfather mother father sister(s) brother(s) son(s) daughter(s)
Have they ever been treated for their condition? No Yes I don't know

2. Any other hereditary conditions the doctor should be aware of? No Yes: _____

SOCIAL HISTORY

- 1. **Smoking:** cigars pipe cigarettes How often? Daily Weekends Occasionally Never
- 2. **Alcoholic Beverage:** consumption occurs Daily Weekends Occasionally Never
- 3. **Recreational Drug use:** Daily Weekends Occasionally Never
- 4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect? (See ADL form)

I hereby authorize payment to be made directly to **Upward Shift Chiropractic**, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to **Upward Shift Chiropractic** for any and all services I receive at this office.

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:

EFFECT:

Carry Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sit to Stand	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Climb Stairs	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Pet Care	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Extended Computer Use	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Lift Children/Groceries	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Read/Concentrate	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Getting Dressed	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Shaving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sexual Activities	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sleep	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Sitting	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Static Standing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Yard work	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Walking	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Washing/Bathing	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Sweeping/Vacuuming	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Dishes	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Laundry	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Garbage	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Driving	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform
Other: _____	<input type="radio"/> No Effect	<input type="radio"/> Painful (can do)	<input type="radio"/> Painful (limits)	<input type="radio"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

PATIENT'S NAME: _____ HR#: _____ DATE: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

Patient or Authorized Person's Signature

____ - ____ - ____
Date Completed

Doctor's Signature

____ - ____ - ____
Date Form Reviewed

OTHER COMMENTS:

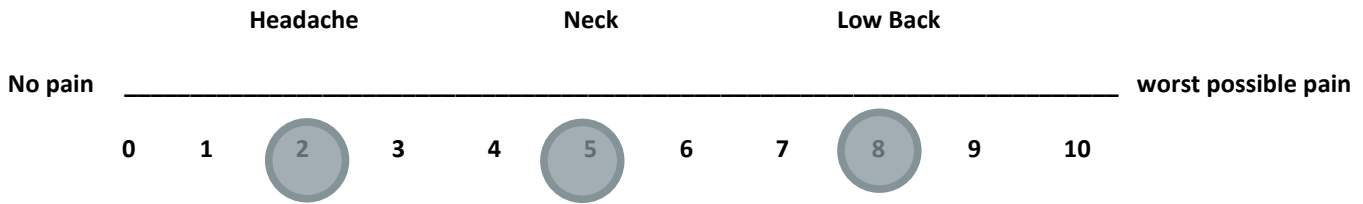
Examiner Reprinted from Spine, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Please read carefully:

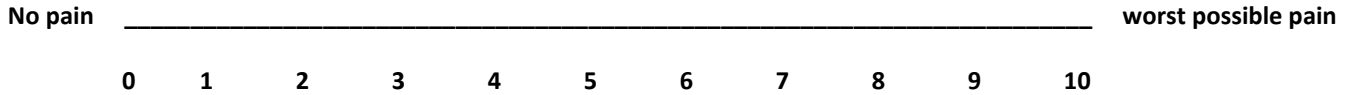
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

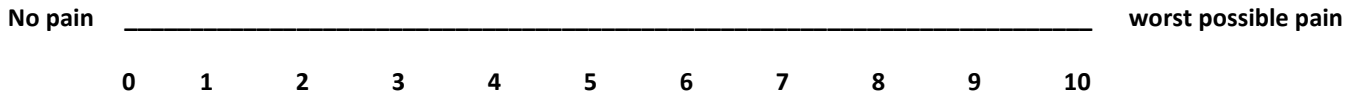
Example:



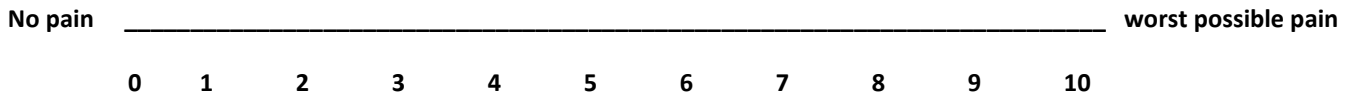
1 – What is your pain RIGHT NOW?



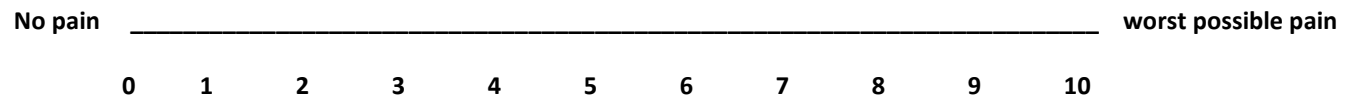
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



UPWARD SHIFT CHIROPRACTIC

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at **Upward Shift Chiropractic** have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Name (print)

Patient or Authorized Person's Signature

____/____/____
Date



Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Name (print)

Patient or Authorized Person's Signature

____/____/____
Date



Witness Initials

UPWARD SHIFT CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled '**HIPAA**' on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Dan Taylor (239-231-2136). If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

**Medical Information Release Form
(HIPAA Release Form)**

Name: _____ Date of Birth: _____

Release of Information:

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

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

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

Messages:

Please call my home my work my mobile number: _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (*day*) _____ between (*time*) _____

Signed: _____ Date: _____

Witness: _____ Date: _____