ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

Application for Care

Name _____ Date: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred By _____ E-mail _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Marital Status □ S □ M □ D □ W

Spouse's Name _____ Spouse's Occupation _____ # of Children/Ages _____

Previous chiropractor _____ Approx. date of last visit_____

Chiropractic techniques you've had success with _____

If pregnant, how many weeks? ___ Due Date_____Name of OB/midwife_____

Ins Co._____ Policy Number_____ Group Number _____

Subscriber's Name_____ Subscriber's Date of Birth_____

The information in this section pertains to your history from birth to age 5, if you don't know just write "D.K."

Yes	**No**		**Patient Comment if answer is Yes**	**Chiropractor's Comment**
		1. Your mother's pregnancy with you		
□	□	Was she in good health through her pregnancy?	_____	_____
□	□	Have any falls or injuries during pregnancy?	_____	_____
□	□	Experience any physical and/or mental abuse?	_____	_____
		2. Birth Process	_____	_____
□	□	Was the delivery long or difficult?	_____	_____
□	□	Mother given drugs during delivery?	_____	_____
		Forceps or Cesarean? Breech? Circle one if it applies	_____	_____
		Home birth? Hospital birth? Circle one	_____	_____
		3. Growth and Development		
□	□	Were you taught how to care for your spine?	_____	_____
□	□	Did you fall out of bed? Did you fall down the stairs?	_____	_____
□	□	Were you breastfed?	_____	_____
□	□	Childhood sicknesses?	_____	_____
□	□	Accidents? Falls? Injuries?	_____	_____
□	□	Surgery? Drugs?	_____	_____
□	□	Child abuse?	_____	_____
□	□	Spanking (how?)	_____	_____
□	□	Chair pulled out when sat down?	_____	_____
□	□	Were you yanked by your arm?	_____	_____

Yes	No	(Age 5 - Present)	Patient Comment if answer is Yes	Chiropractor's Comment
□	□	Did/do you smoke?	_____	_____
□	□	Did/do you drink any alcohol?	_____	_____
□	□	Have you had surgery or organs removed/replaced?	_____	_____
□	□	Drugs? (Prescriptive or non-prescriptive)	_____	_____
□	□	Teeth, eye or hearing problems?	_____	_____
□	□	Have you been in accidents?	_____	_____
□	□	Exercise regularly?	_____	_____
□	□	Did/do you have occupational stress?	_____	_____
□	□	Physical stress? Mental Stress?	_____	_____
□	□	Hobbies/Sports injuries	_____	_____
□	□	Other traumas or problems?	_____	_____
□	□	Sleeping posture □ side □ stomach □ back	_____	_____

Reason for visiting us _____

If pain, when did it start? _____

Pains are □ Sharp □ Dull □ Constant □ Intermittent Getting worse? □ Yes □ No

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? _____

Is this condition interfering with work? □ Yes □ No Sleep? □ Yes □ No Routine? □ Yes □ No

Other doctors seen for condition _____

Any home remedies? _____

What have you heard about chiropractic care? _____

Do you know what a subluxation is? Please describe _____

_____

What daily rituals for spinal health do you practice? _____

Other symptoms:

□ Headaches	□ Pins and needles in arms	□ Dizziness, fainting
□ Neck Pain	□ Pins and needles in legs	□ Loss of smell
□ Upper back, shoulder pain	□ Numbness in arms, hands, fingers	□ Loss of taste
□ Mid back pain	□ Numbness in legs, feet, toes	□ Diarrhea
□ Low back pain	□ Shortness of breath	□ Feet cold
□ Hip pain	□ Fatigue	□ Hands cold
□ Pain in arms, hands	□ Depression	□ Stomach upset
□ Pain in legs, feet	□ Lights bother eyes	□ Constipation
□ Difficulty in raising legs	□ Loss of memory	□ Loss of Balance

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES

(904)247-3933 or (904)479-0363

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment – An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health – A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation – A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of metal impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I hereby authorize payment directly to this office for professional services rendered and shall be personally responsible for any unpaid balance to the doctors. I hereby authorize the attending doctor to release any information concerning my examination or treatment. If an outstanding balance is not paid within 30 days, I will be responsible for all costs incurred for collections, including reasonable attorney fees.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

Name_____Signed_____

Date_____

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Please initial **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

____ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for four years.

Please initial **TREATMENT AUTHORIZATION**

____ I understand that if I am accepted as a patient by Alterman & Johnson Family Chiropractors, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic care will be explained to me upon my request.

____ I hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this time. PLEASE LEAVE THIS BLANK IF YOU ARE PREGNANT

____ I consent to receiving voicemail/text messages from Alterman & Johnson Family Chiropractors/Blooming Bellies related to my protected healthcare information at (phone number) _____. I understand I may be charged for such calls by my wireless carrier.

_____

Print Name Date

_____

Signature (Patient or Parent/Guarding)

AUTHORIZATION FOR TREATMENT OF MINOR

I hereby authorize of Alterman & Johnson Family Chiropractors to administer treatment as they deem necessary to my child (name)_____.

_____

Parent/Guardian Signature Date

ALTERMAN & JOHNSON FAMILY CHIROPRACTORS and BLOOMING BELLIES
REVIEW OF SYSTEMS

NAME_____ SIGNATURE _____ DATE_____

ALLERGIC/IMMUNOLOGIC
__ Hives/Eczema __ Hayfever __ Catch colds easily __ Frequent sinus trouble
__ Frequent Influenza __ HIV/AIDS __ Fever __ Allergies

CARDIOVASCULAR
__ Murmur __ Chest pain __ Palpitations __ Dizziness
__ Shortness of breath __ Swollen ankles __ Irregular heart beat __ Heart attack
__ Pressure over chest __ Pain down left arm __ High triglycerides __ High cholesterol
__ Profuse sweating __ Nausea __ Vomiting __ Low blood pressure
__ Fainting spells __ High blood pressure __ Difficulty lying flat

CONSTITUTIONAL
__ Weight loss __ Fatigue __ Fever

EARS/NOSE/THROAT
__ Difficulty hearing __ Buzzing in ears __ Ringing in ears __ Vertigo
__ Sinus trouble __ Nasal stuffiness __ Hearing loss __ Ear pain
__ Mouth sores __ Hoarseness __ Nose bleeds __ Dental problems
__ Frequent sore throat __ Difficulty swallowing

ENDOCRINE
__ Loss of hair __ Heat/cold intolerance __ Hypothyroidism __ Hyperthyroidism
__ Diabetes __ Goiter

EYES
__ Glasses/contacts __ Eye pain __ Light bothers eye __ Double vision
__ Cataracts __ Vision problems __ Blurred vision __ Glaucoma

GASTROINTESTINAL
__ Reflux __ Nausea/vomiting __ Constipation __ Change in bowel movements
__ Diarrhea __ Black or bloody stools __ Gallbladder problems __ Liver problems
__ Hepatitis __ Distress from greasy food __ Heartburn __ Ulcers
__ Hiatal hernia __ Colitis __ Blood in stool __ Colon cancer
__ Abdominal pain __ Burning in stomach __ Pancreatitis __ Jaundice
__ Pain in stomach __ Mucus in stool

GENITOURINARY
__ Burning/frequency __ Blood in urine __ Erectile dysfunction __ Abnormal discharge
__ Leakage __ Incontinence __ Kidney infection __ Sexual difficulty
__ Kidney stones __ Loss of libido

HEMATOLOGY/LYMPH
__ Easy bruising __ Gums bleed easily __ Enlarged glands __ Anemia
__ Bleeding disorder __ Sickle cell anemia __ Lymphoma

MUSCULOSKELETAL
__ Joint pain/swelling __ Stiffness __ Muscle pain __ Neck pain
__ Stiff neck __ Back pain __ Osteoarthritis __ Rheumatoid arthritis
__ Bone spurs __ Broken bones __ Compression fracture __ Head injury
__ Back injury __ Spinal trauma __ Birth trauma __ Birth defects
__ Cancer __ Muscle weakness __ Muscular dystrophy __ Scheuerman's disease
__ Scoliosis __ Lupus __ Spina bifida __ Spondylolisthesis
__ Arthritis __ Neck injury __ Osteoporosis

NEUROLOGICAL
__ Loss of strength __ Numbness __ Headaches __ Heavy head
__ Tremors __ Memory loss __ Difficulty speaking __ Multiple sclerosis
__ Parkinson's disease __ Fainting __ Concussion __ Migraines
__ Disorientation __ Loss of coordination __ Difficulty walking __ Stroke
__ Alzheimer's disease __ Weakness __ Disc problem __ Lightheaded/dizzy
__ Epilepsy/seizures __ Tingling

PSYCHIATRIC
__ Anxiety __ Depression __ Mood swings __ Difficulty sleeping
__ Nervousness __ Tension

RESPIRATORY
__ Cough __ Coughing blood __ Wheezing __ Chills
__ Chronic cough __ Pneumonia __ Asthma __ Superficial breathing
__ Chest pain __ Tuberculosis __ Bronchitis __ Emphysema
__ Difficulty breathing __ Lung cancer

SKIN
__ Rash/sores __ Lesions __ Itching/burning __ Skin problems
__ Slow healing __ Bruise easily __ Psoriasis __ Change in moles
__ Change in skin color __ Skin cancer __ Scars __ Discolorations

WOMEN ONLY
__ Hot flashes __ Vaginal discharge __ Nipple discharge __ Menstrual cramps
__ Premenstrual depression __ Lumps in breast(s) __ Hysterectomy
Date of last Mammogram: _____ __ Normal Mammo. __ Abnormal Mammo.
Date of last PAP: _____ __ Normal PAP __ Abnormal PAP
Age onset of periods: _____ Age onset menopause: _____ __ Regular periods? ___Y ___N Number of pregnancies: ___

MEN ONLY
__ Burning on urination __ Difficulty starting urine __ Dripping urination __ Prostate trouble

GENERAL
__ Recent weight gain (other than pregnancy) __ Loss of sleep __ Recent weight loss __ Loss of apetite
__ Fatigue __ Polio __ Rheumatic fever __ Cancer of any kind