BOCA CHIROPRACTIC
SPINE AND WELLNESS

NEW PATIENT APPLICATION

DEMOGRAPHICS

Name: ____ (Age) ________

Cell Phone:______________________________ Gender: M F

Home Address: ____

City, State, Zip: ____

Email Address: ____

Birth Date: _______ / _______ / ________ Social Security #: _______- _______ - ________

Marital Status: S M D W

Occupation: ____

How were you referred to this office? ____

PURPOSE OF VISIT

Reason for this visit – Main Complaint:____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _________

When did this condition begin? ___________/_____/_________

Did it begin: Gradual Sudden Progressive over time

Rate the severity on a scale from 0-10:____

What activities aggravate your symptoms?

____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No

Describe:____

Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the Pain Radiate into your: ____Arm ____Leg ____Does not radiate

Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms? 100% 75% 50% 25% 10%

Does complaint(s) interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine

Explain: ____

Have you experienced this condition before? ☐ Yes ☐ No

If so, please explain: ____

Who have you seen for this? ____

What type of treatment/therapy was done?____

How did you respond? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? ______________________________

When? ________________________ For How Many Sessions? ____________________________

Reason for visits: _________________________ How did you respond? __________________

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

Are you aware of any of your poor posture habits? ☐ Yes ☐ No

Explain: ____

Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No

The most common postural weakness is "Tech-Neck" or Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health.

Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? ____________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? ____

Do you drink alcohol? Yes No How much / week? ___________________________________

Do you drink coffee? Yes No How many cups / day? ________________________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____________________________

Please list any health conditions not mentioned: ______________________________________

Please list any medications currently taking and their purpose :___________________________

Please list all past surgeries: ____

Please list all previous accidents and falls: ____

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Corrective Chiropractic & Rehab facility we have one main goal, **TO FIX THE UNDERLYING CAUSE OF ANY AND ALL HEALTH CONDITIONS & SYMPTOMS**. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease

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 mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

CONSENT TO CARE

I do hereby authorize the doctors of Boca Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures.

Signature____________________________________ Date ________________
(If under age 18) Parent's signature

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: _____________ ______________________ __________
Signature (parent if minor) Date

Consent to x-ray: I hereby grant Boca Chiropractic permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

___________________________ ___________________
Signature (parent if minor) Date

Consent to evaluate and adjust a minor child: I, _________________ being the parent of legal guardian of __________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

___________________ ___________
Signature Date