POSTURE & SCOLIOSIS INSTITUTE

Patient Application

We specialize in assisting our patients achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____ _____

Patient's Name (Please Print) Date

_____

Patient's Signature

POSTURE & SCOLIOSIS INSTITUTE

Patient Application

Full Name _____ Today's Date _____ Marital Status S M W D ☐☐☐☐

Date of Birth _____ Age _____ Gender ❑ F ❑ M

Email _____ Height _____ Weight _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Occupation _____ Employer Name _____

Emergency Contact _____ Emergency Phone _____

Preferred Language _____ Race _____ Ethnicity_____

Who Should We Thank for Referring You to Posture & Scoliosis Institute? _____

Purpose of Visit

Health Issue	Date Started	Frequency	Severity

Are these conditions getting worse? ❑ Yes ❑ No Is this ❑ Constant ❑ Frequent ❑ Occasional ❑ Activity Based

How would you describe your pain or discomfort? ❑ Dull ❑ Achy ❑ Stiff ❑ Sharp ❑ Stabbing ❑ Burning ❑ Intense ❑ Throbbing ❑ Shooting ❑ Constricting

Does your condition interfere with: ❑ Work ❑ Sleep ❑ Hobbies ❑ Other _____

What conditions aggravate your symptoms? ❑ Coughing ❑ Sneezing ❑ Bearing Down ❑ Lifting ❑ Bending ❑ Pushing ❑ Pulling ❑ Driving ❑ Sitting ❑ Walking ❑ Running ❑ Standing ❑ Laying Down

Is there anything that relieves your symptoms? ❑ Ice ❑ Heat ❑ Massage ❑ Resting ❑ Exercise ❑ Sitting ❑ Standing ❑ Bracing / Taping ❑ Stretching ❑ Popping Joints ❑ Laying Down ❑ Nothing Helps

Does your pain radiate from the primary area? ❑ Yes ❑ No If yes, where? _____

Do you experience numbness / tingling anywhere? ❑ Yes ❑ No If yes, where? _____

Who have you seen for this? ❑ Yes ❑ No What did they do? _____ How did you respond? _____

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

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Scoliosis Information

When did you first notice Postural Asymmetries / Poor Posture (if any)? _____

When were you diagnosed? _____ Do you know what areas / degrees? _____

Cobbs Angle _____ Risser Ferguson Angle _____

When was the last time you were: X-Rayed _____ MRI _____

Did you know scoliosis / postural distortions progress every year? ❑ Yes ❑ No

Considered a surgery candidate? _____ Have you been offered bracing for your scoliosis? ❑ Yes ❑ No

Do you have a family history of Scoliosis? ❑ Yes ❑ No Did you know it's genetic? ❑ Yes ❑ No

Have you had a Scoliosis Treatment / Orthopedic consult? ❑ Yes ❑ No

Have you noticed poor posture / postural asymmetries in other members of the family? ❑ Yes ❑ No

Goals for treatments? _____

Has your scoliosis been linked to any congenital or neurological conditions that you know of? ❑ Yes ❑ No

Note: If you qualify for the Scoliosis Correction Program we offer, the program requires a financial and time commitment including home traction / exercises. If accepted, are you willing to commit to the program to get the results you are looking to achieve? ❑ Yes ❑ No

On a scale from 0-10, with 10 being the highest level of commitment, rate your commitment level: _____

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Health Lifestyle

Do you exercise? ❑ Yes ❑ No How often? 1x 2x 3x 4x 5x 6x 7x per week

What activities? ❑ Cardio ❑ Weight Training ❑ Cycling ❑ Yoga/Pilates ❑ Other _____

Do you smoke? ❑ Yes ❑ No How much? _____ Former Smoker? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No How much? _____

Do you drink coffee? ❑ Yes ❑ No How much? _____ Supplements? ❑ Yes ❑ No

Cervical Spine - Do you experience…

❑ Neck Pain	❑ Headaches / Migraines	❑ Thyroid Issues	❑ Brain Fog
❑ Pain in Arms / Hands	❑ Recurring Colds / Flu	❑ Fatigue / Fibromyalgia	❑ ADHD / Difficulty Focusing
❑ Tingling / Numbness	❑ Allergies	❑ Sinusitis	❑ Ringing in Ears
❑ Insomnia	❑ Cold / Sweaty Hands	❑ Weakness in Grip	❑ Depression / Anxiety
❑ Low Metabolism	❑ Mood Swings	❑ TMJ / Jaw Pain	❑ Dizziness / Vertigo

Upper Back - Do you experience…

❑ Heart palpitation	❑ Heart murmurs	❑ Asthma/ wheezing
❑ Tachycardia	❑ Shortness of breath	❑ Heart attacks/angina
❑ Recurrent lung infections/bronchitis	❑ Pain on deep inhalation / exhalation	

Mid Back - Do you experience…

❑ Mid back pain	❑ Nausea	❑ Indigestion/heartburn
❑ Pain into your ribs/chest	❑ Ulcers/gastritis	❑ Hypoglycemia
❑ Acid reflux	❑ Tired/irritable after eating or when you haven't eaten	

Low Back - Do you experience…

❑ Low Back Pain	❑ Constipation/diarrhea/gassiness/ bloating
❑ Numbness/tingling in your legs/feet	❑ Recurrent bladder infection
❑ Weakness/Injuries in hips/knees/ankles	❑ Frequent/difficulty urinating
❑ Muscle cramps in your legs/feet	❑ Menstrual irregularities/cramping (females)
❑ Coldness in your legs/feet	❑ Sexual dysfunction
❑ Pain into your hips/legs/feet	

Please list any health conditions not mentioned: _____

_____

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Medical History

Do you or any one in your family been diagnosed with any of the following:

❑ Diabetes	❑ Varicose Veins	❑ Neurological Issues	❑ Lung Disease
❑ Rheumatic Fever	❑ Circulatory Problems	❑ Stroke	❑ Heart Murmurs
❑ High Blood Pressure	❑ Heart Disease	❑ Cancer	❑ Osteoporosis
❑ Kidney Disease	❑ Seizures	❑ Migraine	❑ Headaches
❑ Liver Disease	❑ Metal Implants	❑ Infectious Disease	❑ Gallbladder
❑ Broken Bones	❑ Appendectomy	❑ Tonsillectomy	❑ Hernia
❑ Pneumonia	❑ Polio	❑ Tuberculosis	❑ Anemia
❑ Whooping Cough	❑ Chicken pox	❑ Mumps	❑ Measles
❑ Thyroid	❑ Small Pox	❑ Influenza	❑ Pleurisy
❑ Arthritis	❑ Epilepsy	❑ Difficulty Urinating	❑ Eczema
❑ Gout	❑ Prostate	❑ Glaucoma	❑ AIDS

Current Medications:
Over the counter medications _____

Prescription medication (please list) _____

Others/supplements (please list) _____

Please list any medication you are allergic to _____

Please list any allergies and reactions _____

Previous surgeries (all type) Approximate date

1. _____ _____
2. _____ _____
3. _____ _____

Primary Care Physician

Name _____ Specialty _____

Address _____ City _____ Zip _____

Phone _____ Last Date of Visit _____

In order to provide complete and wholesome care, we will communicate with your primary care physician regarding past, present, and future health concerns. By signing below, you authorize Posture & Scoliosis Institute to contact your physician, request medical records, and/or co-manage your healthcare needs.

_____ _____ _____
Patient's Name (Please Print) Date Patient's Signature

_____ _____ _____
Minor's Name (Please Print) Date Guardian's Signature

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Pain Dysfunction Questionnaire

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time. Please answer every question by circling the number that corresponds to how much your pain or discomfort has affected you.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally 0 1 2 3 4 5 6 7 8 9 10 Unable to work at all

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
I take care of myself 0 1 2 3 4 5 6 7 8 9 10 Need help with personal care

3. Does your pain interfere with your traveling?
Travel anywhere I like 0 1 2 3 4 5 6 7 8 9 10 Travel to see a doctor

4. Does your pain affect your ability to sit or stand?
No problems at all 0 1 2 3 4 5 6 7 8 9 10 Cannot sit or stand at all

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems at all 0 1 2 3 4 5 6 7 8 9 10 Cannot do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems at all 0 1 2 3 4 5 6 7 8 9 10 Cannot do at all

7. Does your pain affect your ability to walk or run?
No problems at all 0 1 2 3 4 5 6 7 8 9 10 Cannot walk / run at all

8. Has your income declined since your pain began?
No decline 0 1 2 3 4 5 6 7 8 9 10 Lost all income

9. Do you have to take pain medication every day to control your pain?
No medication needed 0 1 2 3 4 5 6 7 8 9 10 On medication all day

10. Does your pain force you to see doctors much more often than before your pain began?
I don't see doctors 0 1 2 3 4 5 6 7 8 9 10 See doctors every week

11. Does your pain interfere with your ability to see the people who are important to you often?
No problem 0 1 2 3 4 5 6 7 8 9 10 Never see them

12. Does your pain interfere with recreational activities and hobbies that important to you?
No interference 0 1 2 3 4 5 6 7 8 9 10 Interferes all the time

13. Do you need the help of your family and friends to complete everyday tasks because of your pain?
Never need help 0 1 2 3 4 5 6 7 8 9 10 Ask for their help all the time

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression 0 1 2 3 4 5 6 7 8 9 10 Severe depression and anxiety

14. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
No problem 0 1 2 3 4 5 6 7 8 9 10 Severe problem

FSC_____ PC_____ Total_____

POSTURE & SCOLIOSIS INSTITUTE

Authorization and Privacy

I authorize and agree to allow the doctor to work with my spine through the use of spinal adjustments, CBP® rehabilitation techniques, and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. 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 diagnosed at this clinic. I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor for all services rendered.

_____	_____	_____
Patient's Name (Please Print)	Date	Patient's Signature
_____	_____	_____
Minor's Name (Please Print)	Date	Guardian's Signature

Healthcare Authorization

THE FOLLOWING AUTHORIZES POSTURE & SCOLIOSIS INSTITUTE TO USE AND OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Posture & Scoliosis Institute to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related email messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/ month postings. I give permission to Functional Wellness Center to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving Posture & Scoliosis Institute permission to use and disclose your protected health information in accordance with the directives listed above.

Acknowledgement of Receipt / Notice of Privacy Practices

I understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent, the right to object to the use of my health care information for directory purpose, and the right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment or health care operation.

_____	_____	_____
Patient Name	Date	Patient's Signature
_____	_____	_____
Doctor's Name	Date	Doctor's Signature

POSTURE & SCOLIOSIS INSTITUTE

Informed Consent for Chiropractic Treatment And Financial Agreement

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below), for whom I am legally responsible by the doctor or intern affiliated with Posture & Scoliosis Institute.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interests.

Financial Agreement: I agree that in return for the services provided to me by Posture & Scoliosis Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Posture & Scoliosis Institute for payment. If an account is sent to collections, I agree to pay collection expenses. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits on any type under any insurance policy ensuring the patient or any other party liable to the patient is hereby assigned to Posture & Scoliosis Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill.

Posture & Scoliosis Institute accepts the charge determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance, co-pays, and non-covered services.
Coinsurance and deductibles are based upon the charge determination of the carrier and are due at the time of service.

I also understand that if I cancel or fail to show up for a scheduled appointment at Posture & Scoliosis Institute, I may be charged a cancellation fee which is at the discretion of Posture & Scoliosis Institute.

Assignment of Benefits: I agree that payments intended for Posture & Scoliosis Institute in return for services provided to me which are covered by my insurance policy and are sent to the undersigned patient or authorized recipient on behalf of the patient will be repaid to the Posture & Scoliosis Institute.

I have read, or have had read to me, the above consent. By signing below, I agree to the above, and allow the doctor or intern, affiliated with Posture & Scoliosis Institute to perform such. I intend this consent form and financial agreement to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) Date

_____

Patient's Signature

Posture & Scoliosis Institute
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