



KHORRAMI CHIROPRACTIC WELLNESS CENTER

PATIENT APPLICATION FORM

We specialize in assisting our patients achieve their highest level of health through 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. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Patient Name: _____

Date: _____

Patient Information

PLEASE PRINT CLEARLY:

Today's Date: _____

Full Name: _____ Email: _____ May we e-mail you? Y N

Gender: M F Age: _____ DOB: ____/____/____ Marital Status: S M D W # Children: _____

Work Status: FT PT R Student Address: _____ City: _____ Zip: _____

Home Phone:(____) _____ Cell Phone:(____) _____ Social Security#: _____

Driver's License#: _____

Females: Last Menstrual Period: ____/____/____ Pregnant: Y N

Employer: _____ Occupation: _____

Work Phone: (____) _____ Employer address: _____ City: _____

State: _____ Zip: _____

Spouse, Parent or Guardian Name: _____ Age: _____ DOB: ____/____/____

Spouse's Employer: _____ Occupation: _____ Work Phone: (____) _____

Emergency Contact Person: _____ Relationship to Patient: _____

Do you have health Insurance: Y N Carrier Name: _____ Group Name: _____

Policy# _____ Group # _____ Ins Card Copied DL copied

Who may we thank for referring you? _____ Internet Yellow Page Doctor Yellow Book

Please initial acknowledging that patient is responsible for patient portion of insurance charges and/or payment in full for non-covered items or services. If there is no insurance coverage, patient is responsible for balance of service at time of service each visit: _____

We want you to know how your Protected Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we begin care, please read and sign this consent form stating understanding and acknowledgement regarding how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning of the privacy of your PHI, please ask us for our complete HIPAA Privacy Notice as we have that available upon request at the front desk.

The patient understands and agrees Khorrami Chiropractic Center to use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare options and coordination of care.

The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. Patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This practice is not obligated to comply with those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given to patient in this office.

-Patient may provide a written request to revoke consent at any time during care. This would not affect the sue of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

For your security and right to privacy, the staff has been trained in the area of patient privacy and a privacy official has been designated to insure these procedures in our office. We have taken precautions to assure that your records are not readily available to those unauthorized to access them.

I have read and understood how my PHI will be used and I agree to these policies and procedures. Signature required on last page.

PURPOSE OF THE VISIT

Health Concern: (please list in priority order& use back of questionnaire or additional paper if needed)

Health Issue Date Condition Started Frequency Severity (0-10)

1. _____
2. _____
3. _____

Treatment: What type of treatment are you looking for?

Symptom Relief Correction Care Total Wellness Care All 3 previous choice

Have you previously been treated for this condition by another provider? _____

If yes, by whom? _____ Treatment received: _____

Have you had any reaction to previous treatment: Y N

Describe: _____

If this is a recurrence, when did you initially notice this problem: _____

Symptoms/ Complaints: (Relating to our primary complaints)

When did symptoms begin? _____ What initiated symptoms? _____

Are these conditions getting worse? Yes No

Is this: Constant Frequent Occasional Activity Related

How would you describe your pain / discomfort (check all that apply)

Dull Achy Throbbing Stiff Sharp Stabbing Shooting
 Intense Burning Constricting Other (please describe) _____

Dose your condition interfere with:

Work Sleep Hobbies Daily Routine (please describe) _____

What activities aggravate your symptoms?

Coughing Sneezing Bearing Down Lifting Bending Pushing Pulling Driving Sitting
 Walking Running Standing Laying down Movement

Is there anything, which has relieved your symptoms? Yes NO

Ice Heat Massage Resting Exercise Sitting Standing
 Bracing/ Taping Stretching Popping Joints Laying Others _____

Do you have other conditions or symptoms that may be related to current symptoms? Y N If yes, what?

Have you ever been in an auto accident or other physical trauma: Past year 1-5 years 5+ years Never

Describe: _____

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

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

Who have you seen for this? _____ What did they do? _____

How did you responds? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? Yes No Who? _____ When? _____
Reason for visits: _____
How did you respond? _____

Did your previous chiropractor take a before and after x-rays? Yes No
Did you know posture determines your health? Yes No
Are you aware of any your poor posture habits? Yes No
Please explain: _____

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening our whole body). Even less severe forms of this posture can cause many adverse effects on your overall health. Have you ever told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of our neck? Yes No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1x 2x 3x 4x 5x per week Other: _____

What activities? Running/ Walking Weight Training Cycling Yoga/Pilates Others: _____

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) _____

Health Conditions

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebra in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations (Sub-lux-a-shuns). It has been extensively documented that subluxation causing stress to your nerves, will weaken and distort the overall structural of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called forwarded head syndrome (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK)

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience:

Neck Pain Thyroid Conditions TMJ/ Pain/ Clicking General Fatigue
 Headaches/ Migraines Sinusitis Dizziness Insomnia
 Allergies/hay fever Hearing disturbances Visual disturbances Low Metabolism
 Recurrent colds/flu Weakness in grip Coldness in hands
 Pain into your shoulders/ arms/ hands Numbness/ tingling in arms/ hands

THORACIC SPINE (UPPER BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience:

Heart palpitation Heart murmurs Asthma/ Wheezing
 Tachycardia Shortness of breath Heart attacks/ angina
 Recurrent lung infections/bronchitis Pain on deep inspiration /expiration

THORACIC SPINE (MID BACK)

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body.

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

LUMBAR SPINE (LOW BACK)

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body.

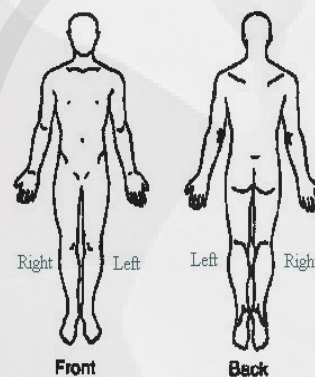
Do you experience:

- Pain into your hips/legs/feet
- Weakness/injures in your hips/knees/ankles
- Numbness/ tingling in your legs/feet
- Recurrent bladder infection
- Coldness in your legs/feet
- Frequent/ difficulty urinating
- Muscle cramps in your legs/feet
- Menstrual irregularities/ cramping (female)
- Constipation/ diarrhea
- Sexual dysfunction
- Low back pain

Please list any health conditions not mentioned: _____

MEDICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tingling in Feet |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Sore Muscle |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea /Vomiting | <input type="checkbox"/> Weak Muscle |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Fullness of Bladder | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Urination Difficulty | <input type="checkbox"/> Sweating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Elbow/Hand Pain | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Varicose Vine |
| <input type="checkbox"/> Swallowing Pain | <input type="checkbox"/> Clammy Hands | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Low back Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Persistent coughing | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chest Pressure | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Swollen Joint | <input type="checkbox"/> Ankle/Foot Pain |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Joint Stiffness | |
| <input type="checkbox"/> Surgically Implanted | <input type="checkbox"/> Device/pacemaker | |



Please use the legend symbols below to accurately mark the areas in which you feel these sensations.
Stabbing: III Tingling: XXX Numbness: ----- Dull: ##### Cramping: ^^

Allergies: (Please check and list all that apply)

Food: _____

Medications: _____

Seasonal: _____

Others: _____

Medications: Please list all medications you are taking, their intended purpose and the date you began taking them:

Scars/Surgical Procedures (Please list all):

Supplements: Do you take vitamins/supplements or herbs?

Miscellaneous & Habits:

Are you Left handed Right handed Ambidextrous Exercise: Light Moderate Heavy Type: _____
Frequency: _____ Approximately how many hours do you sleep per night?

How many meals per day do you eat? _____ How much water per day do you drink: _____

Alcohol consumption: Light Moderate Heavy None

Soda, Diet Soda: light Moderate Heavy None

Tobacco: Light Moderate Heavy None

Stress Level: Light Moderate Heavy None

Work Activity: Heavy Labor Light Labor Mostly Standing Walking /Moving Driving

Uninterrupted Sleep: Y N Do you feel rested upon waking? Y N Vivid Dreams?

How many bowel movements do you have each day? _____

PERSONAL & FAMILY HISTORY: Identify conditions that you or any of your family members have now or have previously had. (G_ Grandparents, M=Mother, F= Father, S=Sibling, X=Self)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Miscarriage(S) | <input type="checkbox"/> Tumor (s) |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Over Weight |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Polio | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Detached Retina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Stroke | <input type="checkbox"/> Female/Organ Dysfunction |

Informed Consent to Chiropractic, Acupuncture and Massage Care

Chiropractic Adjustment: The doctor will use his/her hands or a mechanical device in order to adjust your spinal joint. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a “click” or “pop” as well as a movement of the joint. Various ancillary procedures such as, support pillows, traction or hot/cold packs may also be used.

Risk: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days after treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Acupuncture: The provider will use procedures including but not limited to acupuncture, moxabustion, cupping, electro acupuncture, herbology and modes of physiotherapy.

Risks: Risks include but are not limited to slight bruising, tingling near the needling sites that may last a few days, nausea, infection and blisters. There have been reported instances of fanning, scarring, spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy.

Massage: The provider will perform soft tissue or muscle work using his/her hands.

Risks: Risks may include muscle weakness, muscle and joint soreness, ligament strain, muscular strain.

Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been describes as “rare”. The risk of cerebrovascular injury or stroke has been estimated at one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be “rare”.

Other Treatment options which could be considered may include:

Over the counter analgesics may cause irritation to the stomach, liver and kidneys, and other side effects in 1,000 to 4,000 people per one million, and reportedly 16,500 die annually from their use.

Medical care typically includes anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization and bed rest, in conjunction with medical care adds risks of exposure to virulent communicable disease, loss of muscle tone and strength at the rate of 4% per day.

Surgery, in conjunction with medical care adds the risks of infections, adverse reaction to anesthesia, disfiguring scar as well as an extended convalescent period in a significant number of cases. Serious neurological complications from neck surgery are 15,600 per million, mortality rates are 6,900 per million.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycle. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following risks of my case explained to me. If you/and /or the individual listed below understand the above information, please sing below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.

I have read or have read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

Patient/ guardian print name

Signature

Date