exodus CHIROPRACTIC

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Knoxville, TN 37934
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www.exoduschiropractic.com

NEW PATIENT APPLICATION

HR#________________

PERSONAL INFORMATION

Name:_______________________ Preferred Name:______________ Today's Date: ____/____/_____

Date of Birth: ____/____/_______ Age: _________ Gender: ☐Male ☐Female Height _______ Weight_________

Address: ______________________________ City ________________ State:__________ ZIP___________

Home Phone #__________________ Cell # ___________________ Email___________________________

Status: ☐Single ☐Married ☐Divorced ☐Widowed Spouse's Name_________________________________

Occupation______________________________ Employers Name______________________________

Name and Ages of Children________________________ Preferred Methods of Contact: ☐Text ☐Phone Call ☐E-Mail

Whom may we thank for referring you to our office? _____________________________________

HEALTH PROFILE

☐ I ***DO NOT*** have symptoms. I am seeking chiropractic care for Wellness Care
☐ I ***DO*** have symptoms for which I am seeking chiropractic care (list all your symptoms below)

Health Concerns	Severity Rating	When did this begin?	Was this due to an injury?
1. ______________________	(complete page 3)	________________	______________
2. ______________________	(complete page 3)	________________	______________
3. ______________________	(complete page 3)	________________	______________
4. ______________________	(complete page 3)	________________	______________

Since your symptom(s) began, it's getting: ☐ Better ☐Worse ☐Same

What Makes it Worse?______________________________

What Makes it Better?______________________________

Does your symptom(s) travel to anywhere else in your body?

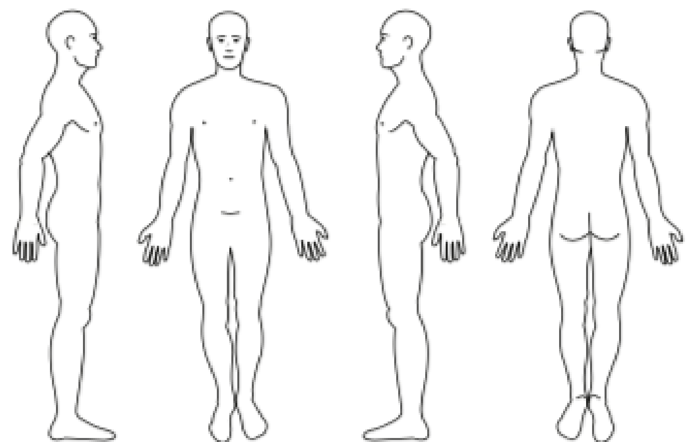
____

When do your symptom(s) occur?

☐Morning ☐Afternoon ☐Constant ☐All Day ☐Night

Other Health Care Providers seen? ____________________

Have you been to a Chiropractor Before? ☐Yes ☐No



On the diagram above, mark the figures to where you experience your body. Use the symbols below:

Symbols:

A = Dull Ache
B = Burning
F = Stiffness
N = Numbness
P = Pressure
R = Radiating
S = Sharp/Stabbing
T = Tingling

MEDICATIONS

☐ Anxiety/Depression ☐ Migraines ☐ Asthma ☐ Pain Narcotics
☐ Antibiotics ☐Acid Reflux ☐ADHD/ADD ☐Digestive
☐ Blood Pressure
☐ Other ______________________________
☐ Other ______________________________

Please Explain any boxes checked above:

____

____

DO YOU HAVE OR HAD?

- ☐ Headaches
- ☐ Fainting
- ☐ Allergies
- ☐ Loss of Smell
- ☐ Nervousness
- ☐ Anxiety
- ☐ Dizziness
- ☐ Depression
- ☐ Heartburn
- ☐ Constipation
- ☐ Pins and Needles in Legs
- ☐ Pins and Needles in Arms
- ☐ Menstrual Irregularity
- ☐ Upset Stomach
- ☐ Difficulty Focusing
- ☐ Lights Bother Eyes
- ☐ Cold Hands
- ☐ Menstrual Pain
- ☐ Ulcers
- ☐ Fatigue
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Urinary Problems
- ☐ Sleep Problems
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Diarrhea
- ☐ Dry Eyes
- ☐ Fever
- ☐ Cold Feet
- ☐ Ringing in Ears
- ☐ Loss of Balance
- ☐ Stiff Neck
- ☐ Dry Skin
- ☐ Hot Flashes
- ☐ Poor Memory
- ☐ Irritability
- ☐ Sinus Issues
- ☐ Frequent Sickness
- ☐ Diabetes

HISTORY

Have you ever had surgery? (List all operations)

1. Type:______________________________________ Year:_________

2. Type:______________________________________ Year:_________

3. Type:______________________________________ Year:_________

Have you ever had a serious illness or Health Emergency ☐No ☐Yes

If Yes, explain ____

Do you have any genetic disorders or disabilities? ☐No ☐Yes

If Yes, explain ____

Do you have Allergies? ______________________________________

Have you ever fractured/broken a bone? ☐No ☐Yes

If Yes, explain ____

How often do you smoke? ☐Never ☐Past ☐ Occasionally ☐ Daily

How often do you consume alcohol? ☐Never ☐Past ☐Occasionally ☐Daily

How often do you exercise? __________________________________

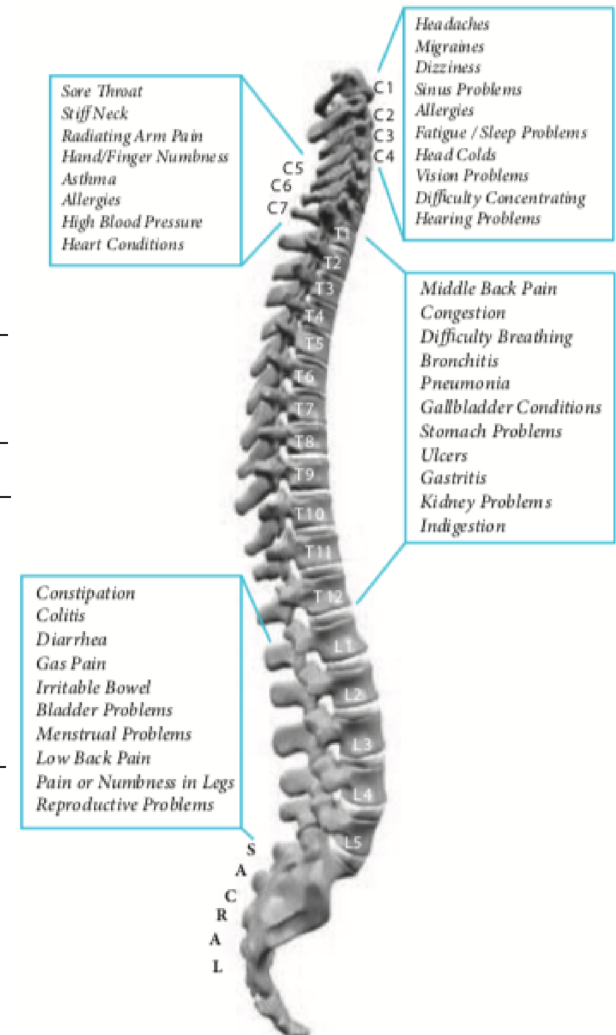
Have you ever been in an accident and/or injury? ☐No ☐Yes
If Yes specify if work related, auto-injury or other

1. Type:______________________________________ Year:_________

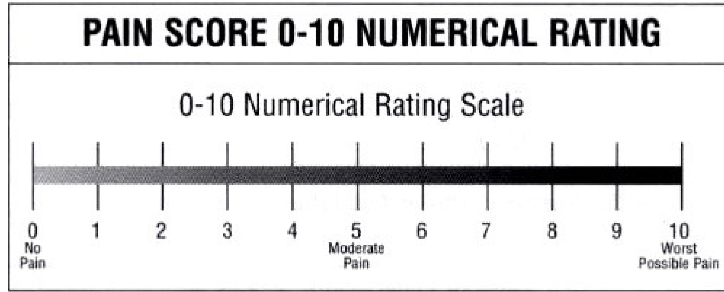
2. Type:______________________________________ Year:_________

3. Type:______________________________________ Year:_________

Did you know your nervous system controls every function in your body?



STRESS ASSESSMENT



Symptom 1:________________________________

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects you.	RATING										
	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

Symptom 2:________________________________

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects you.	RATING										
	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

Symptom 3:________________________________

For each statement below, place an "X" in the "RATING" box to best show how the symptom effects you.	RATING										
	0	1	2	3	4	5	6	7	8	9	10
ON AVERAGE, rate the effect of your symptom.											
RIGHT NOW, rate the effect of your symptom.											
AT ITS BEST, rate how close to "0" your symptom gets.											
AT ITS WORST, rate how close to "10" your symptom gets.											

HEALTH GOALS

- ☐ Relieve Pain/Discomfort
- ☐ Restore Proper Function
- ☐ Increase Energy
- ☐ Improve Posture
- ☐ Improve Mobility
- ☐ Drink More Water
- ☐ Get Adequate Sleep
- ☐ Pregnancy Care
- ☐ Fertility Support
- ☐ Attend Free Health Classes
- ☐ Reduce Medication(s)
- ☐ Improve Diet/Nutrition
- ☐ Improve Focus/Attention
- ☐ Increase Confidence
- ☐ Restore Emotional Health
- ☐ Strengthen Immune System
- ☐ Maintain Healthy Body Weight
- ☐ Financial Stability
- ☐ Other:

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X-RAY AUTHORIZATION

Specific postural x-rays may be necessary for the identification of the location, type and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may be used to show progress after a period of recommended chiropractic care. At your request you can receive a copy of your X-Rays on a disc for a fee of $20.00.
By signing below, I authorize Exodus Chiropractic to perform diagnostic imaging of me.
FEMALES ONLY:
◻ To my best knowledge, there is no chance that I am pregnant at this time.
◻ I know or believe that I may be pregnant at this time and there I ***DO NOT*** authorize X-Rays of me.

INFORMED CONSENT

I hereby consent doctors and staff at Exodus Chiropractic permission and authority to care for me. At Exodus Chiropractic, we do not diagnose or treat any disease or condition other than vertebral sulbuxation and the doctor/clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the staff at Exodus Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic tests, diagnosis and adjustments are very safe and beneficial and rarely cause any risk. In rare cases, underlying physical defects, deformities or pathologies may make the Practice Member prone to injury. It is the pratice member's responsibility to make it known to the doctor. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic. Furthermore, any questions that I have regarding chiropractic care will be explained to me upon my request

HIPAA CONSENT

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payments, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for future appointment reminders, announcements, and to inform you about our practice and its staff. I authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office.
Exodus Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. This notice will display the effective date.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understood your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and disclosed

SOCIAL MEDIA CONSENT

Select an option below:
◻ **I DO** authorize Exodus Chiropractic to display testimonials, photographs and videos of me in the office or on social media outlets. I understand that the purpose of sharing this information is to provide others with chiropractic education and give hope to those seeking answers to their health concerns. My consent remains in effect until revoked by myself in writing.
◻ **I DO NOT** authorize Exodus Chiropractic to display testimonials, photographs, and videos if me in the office or on social media outlets at this time.

Patient Signature *Date*

INSURANCE INFO

Patient Name:____________________________ Date of Birth: ____________ Social Security #____________________

Insurance Company:_______________________________________ Are you responsible for this account? ☐Yes ☐No

Subscriber's Name:_________________________ Date of Birth: _____________ Social Security #____________________

Relationship to Patient (if not self):_______________________ Secondary Insurance Company:______________________

MEDICARE ADVANCED BENEFICIARY NOTICE

Advanced Beneficiary Notice of NON-Coverage (ABN). We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future.) By signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision. If you have other questions please ask our front desk. Signing below means that you have received and understood this notice.

Exodus Chiropractic is a non-par provider in the Medicare program. After you have met your deductible, Medicare Part B pays for a portion of the visits when you are adjusted. They will not pay for other services, ie. X-rays, office visits when there is only a spinal exam given, progress exams and consultations.

FINANCIAL POLICY

By signing below, I recognize that I am financially responsibly for all services rendered to me regardless of insurance or benefits. I further understand that any health insurance policy is an arrangement between me and my insurance carrier and that I may be required to pay for some or all the fees charged to my account.

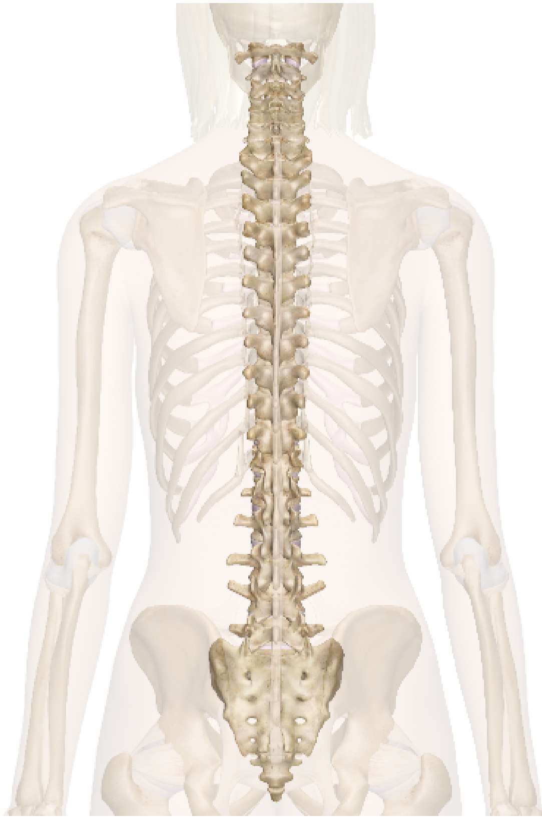
I authorize Exodus Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

It is the policy at Exodus Chiropractic that all charges will be paid by cash, check or credit card at the time services are rendered. If your have any questions about our financial policies please ask our administrative manager. If you need to make special arrangements, please ask.

____ ____________________

Patient Signature *Date*

FOR OFFICE USE ONLY



PALPATORY FINDINGS

C1	L / R / Bilateral	☐ Edema
C2	L / R / Bilateral	☐ Edema
C3	L / R / Bilateral	☐ Edema
C4	L / R / Bilateral	☐ Edema
C5	L / R / Bilateral	☐ Edema
C6	L / R / Bilateral	☐ Edema
C7	L / R / Bilateral	☐ Edema
T1	L / R / Bilateral	☐ Edema
T2	L / R / Bilateral	☐ Edema
T3	L / R / Bilateral	☐ Edema
T4	L / R / Bilateral	☐ Edema
T5	L / R / Bilateral	☐ Edema
T6	L / R / Bilateral	☐ Edema
T7	L / R / Bilateral	☐ Edema
T8	L / R / Bilateral	☐ Edema
T9	L / R / Bilateral	☐ Edema
T10	L / R / Bilateral	☐ Edema
T11	L / R / Bilateral	☐ Edema
T12	L / R / Bilateral	☐ Edema
L1	L / R / Bilateral	☐ Edema
L2	L / R / Bilateral	☐ Edema
L3	L / R / Bilateral	☐ Edema
L4	L / R / Bilateral	☐ Edema
L5	L / R / Bilateral	☐ Edema
SI	L / R / Bilateral	☐ Edema

POSTURE

Anterior Head Carriage: ___________
Hip Hip: L______ R______
High Shoulder: L______ R______
Foot Flare: L______ R______
Bilateral Weight: L______ R______

NOTES

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______________________________________ Examiner Signature

___________ Date