Whom may we thank for referring you to this office _____***?***

APPLICATION FOR CARE AT THRIVE WELLNESS CENTER

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ **Birth Date:** ____-____-____ **Age:** ____ ☐ Male ☐ Female

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____ **Home Phone:** _____ **Cell Phone:** _____

Marital Status: ☐ Single ☐ Married **Do you have Insurance:** ☐ Yes ☐ No **Work Phone:** _____

Current or Past Military: ☐ Yes ☐ No **If so, which branch of the military?** _____

Employer: _____ **Occupation:** _____

Spouse's Name: _____ **Spouse's Employer:** _____

Number of Children & Age: _____

Name of Emergency Contact: _____ **Phone Number:** _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the numbers:**

Primary or chief complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Secondary complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Third complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Fourth complaint is : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

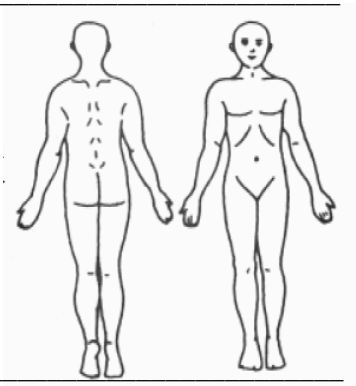
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It's constant **OR** ☐ It's on and off during the day **OR** ☐ It comes and goes throughout the week

How did this injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐ No ☐ Yes **If yes, when:** _____ **By whom:** _____

How long were you under care: _____ What were the results: _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the ares on the Diagram with the following **letters** to describe you symptoms:
R = **R**adiating **B** = **B**urning **D** = **D**ull **A** = **A**ching **N** = **N**umbness **S** = **S**harp/**S**tabbing **T** = **T**ingling

What relieves your symptoms? _____
What makes them feel worse? _____

Is your problem the result of **ANY** type of accident? ☐ Yes ☐ No

LIST RESTRICTED ACTIVITY	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
Example: *Sitting*	*I can only sit for 10 minutes*	*I can't sit as long as I want too*
_____:	_____	
_____:	_____	
_____:	_____	

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ Yes ☐ No **If yes** how many times? _____
When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried? ☐ Yes ☐ No **If yes,** please state what type? _____
Who provided it: _____ **How long ago:** _____
What were the results? ☐ Favorable ☐ Unfavorable **Please explain:** _____

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with the following conditions, please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had:

☐ Cancer ☐ Tumors ☐ Heart Disease ☐ Stroke ☐ Heart Attack ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes
☐ Thyroid Disease ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Kidney Disease ☐ Liver Disease ☐ Ulcers
☐ IBS ☐ Crohn's Disease ☐ Celiac's Disease ☐ Ulcerative Colitis ☐ Gall Bladder Problems ☐ Other Serious Conditions:

Please identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem(s):

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

1. **Smoking:** ☐ Cigars ☐ Pipe ☐ Cigarettes : **How often?** ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. **Alcoholic Beverage:** consumption occurs : ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. **Recreational Drug use:**
4. **Hobbies - Recreational Activities - Exercise Regime:** How does your present problem affect the following. See pg 3: (Activities of Daily Living)

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No
If yes, whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Son(s) ☐ Daughter(s) ☐ Sister(s) ☐ Brother(s)
Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know
2. Any other hereditary condition(s) the doctor should be aware of? ☐ No ☐ Yes: _____

I hereby authorize payment to be made directly to Thrive Wellness Center, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thrive Wellness Center for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient of Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Received**

Patient's Name: _____ **HR#:** _____ _____/_____/_____ **JDD, DC 2/2012**

ACTIVITIES OF DAILY LIVING / SYMPTOMS / MEDICATIONS

Patient Name: _____ **File#:** _____
Date: _____

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition(s) is/are affecting you ability to carry out activities that are routinely part of your life.

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreational Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting or Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Please mark **P** for in the **Past, C** for **Currently Have** and **N** for **Never**

___ Migraines	___ Pregnant (Now)	___ Dizziness	___ Trouble Sleeping or Sleep Apnea
___ Headaches	___ Convulsions/Epilepsy	___ Loss of Balance	___ Heartburn
___ Neck pain	___ Frequent Colds/Flu	___ Fainting	___ Asthma
___ Jaw pain, TMJ	___ Frequent Fevers	___ Vision Problems	___ Difficulty Breathing
___ Shoulder pain	___ Nausea	___ Ringing in Ear(s)	___ Lung Problem
___ Upper Back pain	___ Chest pain	___ Hearing Loss	___ Diarrhea/Constipation
___ Mid Back pain	___ Pain while Coughing or Sneezing	___ Loss of Smell	___ Prostate Problems
___ Low Back pain	___ Foot / Knee Problems	___ Depression	___ Impotence or Sexual Dysfunction
___ Hip pain	___ Sinus Problems	___ Irritable	___ Menopausal Problem
___ Back curvature	___ Swollen/Painful Joints	___ Mood Changes	___ Menstrual Problem
___ Scoliosis	___ Skin Problems	___ ADD/ADHD	___ PMS
___ Numbness/Tingling in Arms, Hands, Fingers		___ Allergies	___ Multiple Sclerosis
___ Numbness/Tingling in Legs, Feet, Toes		___ Eating Disorder	___ Hepatitis (A,B,C)

TRAUMA HISTORY

1. When was your most recent auto accident? _____
   What speed was the collision? _____
   Type of impact: Front impact / Side impact / Rear impact
   Was treatment(s) received? Please describe: _____

2. When was your most recent strain / sprain / stress at work? _____
   Please describe the manner of the injury: _____
   Was treatment(s) received? Please describe: _____
   Does your job require you to remain in long term stressful postures? _____
   (i.e. all day sitting, repeated lifting, long term computer use)

List Prescription & Non-Prescription drug(s) you take:

_____

_____

_____

_____

Doctor's Signature: _____ **Date:** _____ **JDD, DC 2/2012**

NOTICE OF PRIVACY PRACTICE

This office is required to notify you, in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or **as dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to your. In addition, you will find we have placed several copied in report folders labeled **'HIPPA'** on tables in the reception. Once you have read this notice, please initial, sign and date, and return all documents to our front desk receptionist. A copy of this can be attained for your personal records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussions. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public Health and Safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government Agencies or Law Enforcement - to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails & appointment reminders - **we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your **PHI**

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailing to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records (including x-rays) at no charge via usb storage device, when timely notice (72 hours) is provided. If you would like to have a disc of your images or files made, we will be happy to accommodate you. However, you will be responsible for the associated fees.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Thrive Wellness Center at (507) 258-4100. If we are unavailable, you may make an appointment with our office manager to discuss the concerns within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

Please complete the following where indicated and return to our front desk staff.

Patient initial: _____ - **retaining page 1 of 2**

I hereby acknowledge I have read and received a copy of [insert Covered Entity Name] Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name **Date**

_____ _____

Patient's Signature **Telephone**

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Patient's Name: _____

FOR OFFICE USE ONLY:

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

Patient's Name: _____ HR#: _____ Date: _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities and Therapeutic Procedures.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Pratt Family Chiropractic, LLC (DBA: Thrive Wellness Center), have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by means, method and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

X-RAYS/IMAGING STUDIES

MALES ONLY: By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**

FEMALES ONLY: By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful considerations, I therefore, do herby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

Check the boxes, included the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanations.

☐ The first day of my last menstrual cycle was on _____ / _____ / _____ date.

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

☐ I am considered to be, and/or are post-menopausal by my primary medical doctors, and to the best of my knowledge, I am not pregnant.

_____ _____ _____

Patient or Authorized Person's Signature **Date** **Witness' Initials**