



## NEW PATIENT INTAKE APPLICATION

WELCOME TO OUR CLINIC. We specialize in assisting our patients to 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 Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT APPLICATION SURVEY

Full Name: \_\_\_\_\_ Nickname : \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F  
Home Street Address: \_\_\_\_\_ Home Phone: (     ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Marital Status: S M D W Primary Spoken Language: \_\_\_\_\_

Race/Ethnicity:  African American  Arabic  Asian  Caucasian  Hispanic  Native American  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
**Who may we thank for referring you to our office:** \_\_\_\_\_

### PURPOSE OF VISIT

**\*Mark the figures with the symbols describing your pain sensation**

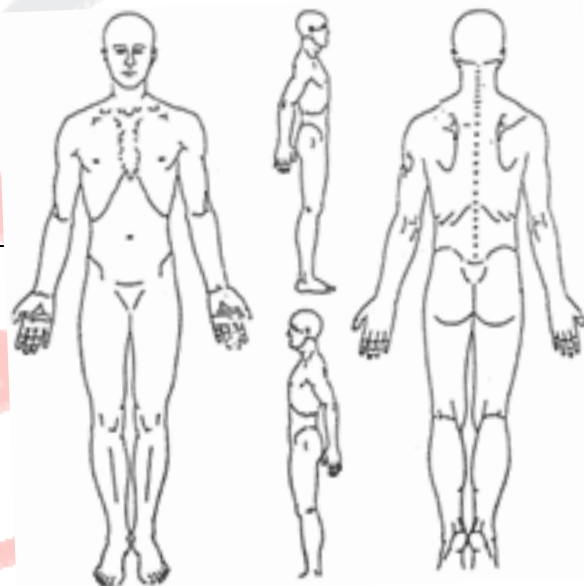
N = Numb   B = Burning   P = Pins/Needles   A = Aching S = Sharp/Stabbing   D = Dull   Other: _____
--

Area(s) of Complaint: \_\_\_\_\_ Onset Date: \_\_\_\_\_

1. \_\_\_\_\_  
Have you had this before?  Yes  No : Injury Related?  Yes  No  
\*This occurs:  Constant  Frequent  Occasional  Seldom

2. \_\_\_\_\_  
Have you had this before?  Yes  No : Injury Related?  Yes  No  
\*This occurs:  Constant  Frequent  Occasional  Seldom

3. \_\_\_\_\_  
Have you had this before?  Yes  No : Injury Related?  Yes  No  
\*This occurs:  Constant  Frequent  Occasional  Seldom



### EXPERIENCE WITH STANDARD CHIROPRACTIC

Have you seen a Chiropractor before?  Yes  No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_  
How did you respond? \_\_\_\_\_  
Did your previous chiropractor take before and after **X-rays**?  Yes  No  
Did your previous chiropractor tell you that **poor posture** can negatively affect your overall health?  Yes  No  
Are you aware of any poor posture habits in your spouse or children?  Yes  No  
Explain: \_\_\_\_\_

### OTHER PROVIDERS

Medical Doctors Seen:  
Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Primary Care Provider?  Yes  No  
Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Primary Care Provider?  Yes  No  
What other testing or treatments have you tried to date for present condition with location (facility) and dates of those tests and treatments: \_\_\_\_\_  
\_\_\_\_\_  
Current over-the-counter medications: \_\_\_\_\_  
Current prescription medications: \_\_\_\_\_  
\_\_\_\_\_

## HISTORY OF PRIMARY COMPLAINTS

Is this the first time you have had this pain?  Yes  No    If No, when was the FIRST time you had these same symptoms? \_\_\_\_\_

How did the CURRENT episode of pain/discomfort occur? \_\_\_\_\_

How did the FIRST episode of pain/discomfort occur? \_\_\_\_\_

Pain severity: If 10 is the worst pain imaginable, and 0 is no pain, please indicate your pain over the last 2 weeks:

Pain Location: _____	Pain Location: _____	Pain Location: _____
RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10	RIGHT NOW: _____ / 10
At its WORST: _____ / 10	At its WORST: _____ / 10	At its WORST: _____ / 10
At its BEST: _____ / 10	At its BEST: _____ / 10	At its BEST: _____ / 10
At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10	At its AVERAGE: _____ / 10

What makes your pain **DIMINISH**? (check all that apply):

Nothing     Ice     Heat     Massage/Rubbing     Exercise/Activity     Sitting  
 Standing     Rest     Stretching     "Popping" the joints     Bracing/taping     Laying  
 Other: \_\_\_\_\_  
 Over-The-Counter Medications: \_\_\_\_\_  
 Prescription Medications: \_\_\_\_\_

What makes your pain **WORSE**? (check all that apply):

Coughing     Sneezing     Bearing Down     Sexual Intercourse     Running     Standing  
 Lifting     Bending     Pushing     Pulling     Driving     Sitting  
 Walking     Laying down     Movement of the head     Movement of the low back  
 Other: \_\_\_\_\_

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

Dull     Achy     Stiff     Intense     Throbbing     Sharp     Sharp with movement  
 Stabbing     Shooting     Burning     Constricting     Annoying     Tight     Unbearable  
 Other: \_\_\_\_\_

Radiating: Does your pain seem to radiate from the primary area:  Yes  No    If Yes, where does the pain radiate to? \_\_\_\_\_

Numbness/Tingling: Do you experience or have you recently experienced numbness and or tingling anywhere?

No  Yes: Please describe where and when you feel these symptoms: \_\_\_\_\_

**Indicate your ability to perform the following activities. Please use the following**

**U-Unable    L-Limited    P-Painful    D-Difficult    N-Normal    H-Haven't Tried**

__ Lying on Back	__ Cough/Sneeze	__ Sleeping	__ Getting In/Out of Car
__ Lying on Side	__ Dressing Self	__ Balancing	__ Walk Short Distances
__ Lying on Stomach	__ Sitting > 1/2 hr	__ Bending Forward	__ Standing > 1 Hour
__ Turning over in bed	__ Reaching	__ Housework/cleaning	__ Laundry
__ Work restrictions: _____	__ Recreation restrictions: _____		

Is your pain/discomfort **WORSE**:

In the morning  
 In the afternoon  
 In the evening  
 While sleeping  
 While awake  
 It does not seem to be affected by the time of day

Is your pain/discomfort **BETTER**:

In the morning  
 In the afternoon  
 In the evening  
 While sleeping  
 While awake  
 It does not seem to be affected by the time of day

## SOCIAL HISTORY AND LIFESTYLE

Do you exercise?  Yes  No How often? 1X 2X 3X 4X 5X per week other: \_\_\_\_\_  
Activities?  Running  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other \_\_\_\_\_  
Do you consider yourself to be...?  Underweight  Normal weight  Overweight  Obese  Severely obese  
Do you smoke?  Yes  No How much? \_\_\_\_\_  
Do you drink alcohol?  Yes  No How much / per  day  week  Month  Year? \_\_\_\_\_  
Do you drink coffee?  Yes  No Cups/day? \_\_\_\_\_ Soda/day? \_\_\_\_\_ Tea/day? \_\_\_\_\_  
What supplements do you take (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend/shift forward with progressive muscle weakening and stretching of your spinal cord). Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or development of a "hump" at the base of your neck?  Yes  No

## CURRENT AND PAST HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned regions of vertebrae in your spine. When these vertebrae are twisted from their normal position, they can cause physical stress to the spinal cord and the delicate nerves that pass between the vertebrae and weaken and distort the overall structure of your spine. This is visualized as weakened and distorted POSTURE. Postural distortions can have many serious and adverse effects on your overall health. Please check any health condition you may be experiencing, now or in the past.

### CERVICAL SPINE (NECK):

Postural distortions from fixations in your neck (such as Forward Head Syndrome) will affect the nerves into your neck, arms, hands and head, negatively influencing these parts of your body. Do you NOW or have you EVER experienced..?

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pain in shoulders/arms/hands	<input type="checkbox"/> Numbness/tingling in arms/hands
<input type="checkbox"/> TMJ/pain/clicking	<input type="checkbox"/> Dizziness/fainting	<input type="checkbox"/> Weakness in grip	<input type="checkbox"/> Arthritis in the neck
<input type="checkbox"/> Allergies/hay fever	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Visual disturbances	<input type="checkbox"/> Hearing disturbances
<input type="checkbox"/> Coldness in hands	<input type="checkbox"/> Low energy/fatigue	<input type="checkbox"/> Recurrent colds/flu	<input type="checkbox"/> Thyroid conditions
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Depression	<input type="checkbox"/> Immune system weakness	<input type="checkbox"/> Other: _____

### THORACIC SPINE (UPPER BACK):

Postural distortions from fixations in the upper back will affect the nerves to the heart and lungs, negatively influencing these parts of your body. Do you NOW or have you EVER experienced ...?

<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Heart attacks/angina	<input type="checkbox"/> Pain on deep inspiration/expiration
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Asthma/wheezing	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Recurrent lung infections/bronchitis

### THORACIC SPINE (MID BACK):

Postural distortions from fixations in the mid back will affect the nerves into your ribs/chest and upper digestive tract, negatively influencing these parts of your body. Do you NOW or have you EVER experienced ...?

<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Pain into ribs/chest	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ulcers/gastritis	<input type="checkbox"/> Indigestion/Heartburn	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Nausea
<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while			<input type="checkbox"/> Liver disease

### LUMBAR SPINE (LOW BACK):

Postural distortions from fixations in the low back will affect the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you NOW or have you EVER experienced ...?

<input type="checkbox"/> Low back pain	<input type="checkbox"/> Pain into hips/legs/feet	<input type="checkbox"/> Weakness/injuries in hips/knees/ankles
<input type="checkbox"/> Numbness/tingling in legs/feet	<input type="checkbox"/> Muscle cramps in legs/feet	<input type="checkbox"/> Recurrent bladder/urinary tract infections
<input type="checkbox"/> Coldness in your legs/feet	<input type="checkbox"/> Frequent/difficulty urinating	<input type="checkbox"/> Menstrual irregularities/cramping (females)
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Sexual dysfunction

**OTHERS:**  Stroke  Parkinson's Disease  Alzheimer's  Cancer: \_\_\_\_\_

Please list any health conditions not mentioned: \_\_\_\_\_

Please list ALL past surgeries w/ dates: \_\_\_\_\_



## INSURANCE AND FINANCIAL OBLIGATION INFORMATION

Do you have insurance?  Yes  No Insurance Co. \_\_\_\_\_ Policy# \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_  
For Automobile Accidents, Insurance Co and Policy Claim Number: \_\_\_\_\_  
For Work Injury, Employer Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Claim No \_\_\_\_\_  
Other than yourself, who else should receive charges on your account? (CHECK ALL THAT APPLY)  
 Spouse  Parent/Guardian  Workers Comp  Auto Insurance  Medicare  Personal Health Insurance

By signing below, I verify that, I clearly understand that all insurance coverage, whether accident, auto, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office **chooses** to bill any services to my insurance carrier this is done strictly as a **convenience** and **courtesy** for me. This office may provide any necessary reports subject to reasonable service fees to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account. **I understand there could be some services that my insurance company does not cover, if this is the case I am willing to pay for these services.**

I also understand that I will be charged \$25 for any and all scheduled appointments that are missed without contacting the office 12 hours in advance. This missed visit fee WILL NOT be covered by insurance and must be paid prior to the next scheduled visit.

Signature of Patient/or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## HEALTHCARE AUTHORIZATION FORM (HIPAA)

THE FOLLOWING AUTHORIZES DR. TRAVIS R. CUNNINGHAM AND DR. SUZI L. CUNNINGHAM TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Dr. Travis R. Cunningham/Dr. Suzi L. Cunningham to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails 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 Dr. Travis R. Cunningham/Dr. Suzi L. Cunningham 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 or assistant in private, the doctor or assistant will provide a private room for these conversations BY APPOINTMENT ONLY.

By signing the following you are giving Dr. Travis R. Cunningham and Dr. Suzi L. Cunningham permission to use and disclose your protected health information in accordance with the directives listed above.

Signature of Patient/or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## 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 rights 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.
- \* 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 operations.

Signature of Patient/or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## FOR OFFICE USE ONLY

Patient's Health Conditions Acceptable for Chiropractic BioPhysics® Corrective Care?  YES  NO

Referred out: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_