

RESTORATION

CHIROPRACTIC

New Practice Member Application

Name _____ Date of Birth ____ / ____ / ____ Age _____ Male/Female
 Address _____ City _____ State _____ Zip _____
 Phone _____ Email _____
 Preferred Contact: Email / Text Message / Phone Call
 Occupation _____ Employer's Name _____
 Status: Single / Married / Divorced / Widowed Spouse's Name _____
 Number of Children: _____ Names, Ages, & Gender _____

 Whom may we thank for referring you? _____

List The Health Concerns That Brought You Into This Office

Health Concern(s): List according to severity. ↓	Rate of Severity 0=No Pain 10= Unbearable	When did the problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary: _____	_____	_____	_____	_____	_____
Second: _____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? ☐ Yes ☐ No

If Yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other _____

Who? _____ When? _____ Results? _____

Please Mark "P" For In the **Past** OR Mark "C" For **Currently** Have:

_____ Headaches	_____ Ear Infections	_____ Sinus Issues	_____ Kidney Problems	_____ Sexual Dysfunction
_____ Migraines	_____ Hearing Loss	_____ Frequent Colds	_____ Bladder Problems	_____ Sleep Problems
_____ Jaw/TMJ Pain	_____ Ringing in the Ears	_____ Thyroid Issues	_____ Menstrual Problems	_____ Tight/Sore Muscles
_____ Neck Pain	_____ Dizziness	_____ Asthma	_____ Prostate Problems	_____ Sports Injury
_____ Shoulder Pain	_____ Loss of Energy	_____ Chest Pain	_____ Infertility	_____ Sciatica
_____ Arm Pain	_____ Nervousness	_____ Heart Problems	_____ Fibromyalgia	_____ Arthritis/Joint Pain
_____ Upper Back Pain	_____ Double/Blurry Vision	_____ Nausea	_____ Epilepsy/Convulsions	_____ GERD/Gastric Reflux
_____ Mid Back Pain	_____ Anxiety	_____ Ulcers	_____ Tremors	_____ Numb/Tingling in Arms/Hands
_____ Lower Back Pain	_____ ADD/ADHD	_____ Digestive Issues	_____ Disc Problems	_____ Numb/Tingling in Legs/Feet
_____ Hip/Leg Pain	_____ Loss of Balance	_____ Diarrhea	_____ Scoliosis	_____ Stomach Problems
_____ Knee Pain	_____ Depression	_____ Constipation	_____ Poor Posture	_____ High/Low Blood Pressure
_____ Foot Pain	_____ Allergies	_____ Bed Wetting	_____ Skin Problems	_____ Difficulty Breathing
_____ Pregnant? Due Date: _____	_____ Stroke	_____ Cancer	_____ Heart Attack	_____ Other: _____
_____ Spinal Surgery	_____ Spinal Bone Fracture	_____ Diabetes	_____ Seizures	

PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching
N = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms?

What makes your symptoms feel worse?

When is the problem(s) at its worst? AM PM Mid-Day Late PM

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

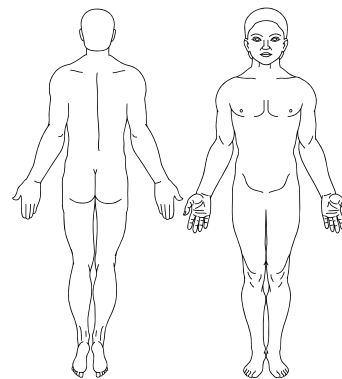
List all over the counter & prescription medications you are on & the reason for each:

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? ☐ Yes ☐ No

Fractured a bone? ☐ Yes ☐ No If yes to either, please describe: _____

Other trauma: _____



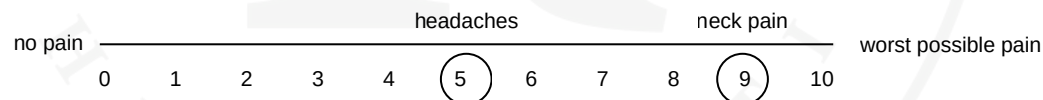
Social History

1. Smoking: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
 2. Alcohol: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
 3. Exercise: How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

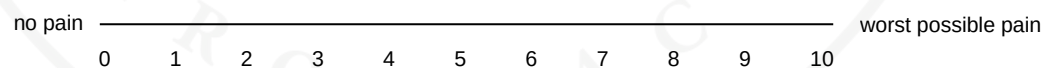
Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE:



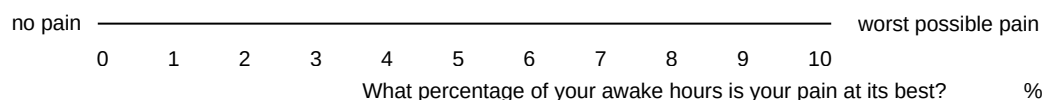
1. How would you rate your pain RIGHT NOW?



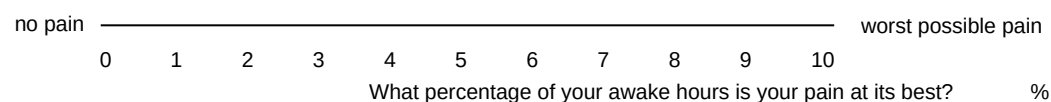
2. What is your typical or AVERAGE pain?



3. What Is your pain level at its BEST? (How close to 0 does your pain get at its best?)



4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)



Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:

EFFECT:

Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Based on what you are presenting with, what activity of daily life would you like to see the most improvement in?

<u>ACTIVITY</u>	<u>CURRENT ACTIVITY LEVEL</u>	<u>GOAL ACTIVITY LEVEL</u>
Example: Sleeping	On and off/ hard to fall asleep	Through the night

Family Health History

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Jacob Schumann, Dr. Stephanie Rodriguez, and all Restoration Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Restoration Chiropractic.

Guardian Signature _____

Relationship to Minor/Child _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide digital copies of your x-rays via email to the email address on file. Digital x-rays will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of Restoration Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Restoration Chiropractic.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbars (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion / Extension:		
Obliques:		

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Jacob Schumann, D.C. and Stephanie Rodriguez D.C., I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

RESTORATION CHIROPRACTIC

1061 N COLEMAN #130 PROSPER TX 75078

GORESTORATIONTX.COM

972-818-5820

TEAM@GORESTORATIONTX.COM

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and 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 you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff.

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we’ve shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient’s death.
9. For workers’ compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued ...

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

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

I hereby acknowledge I have read and received a copy of Restoration Chiropractic 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.

Signature: _____ Date: _____

Print Name: _____ 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

Name of Patient: _____

For Office Use Only

Signed form received by: _____

Reason acknowledgment not obtained: _____

Efforts to obtain: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____