HANSON
CHIROPRACTIC CENTER

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

APPLICATION FOR CARE
PATIENT DEMOGRAPHICS

Date: ____-____-_____

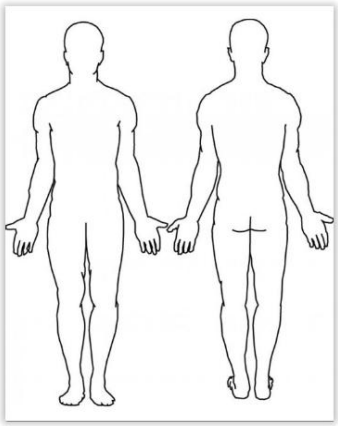
Name: _____ Date of Birth: ____-____-____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____
Cell Phone: _____ Home Phone: _____
Martial Status: ☐ Single ☐ Married Do you have Insurance?: ☐ No ☐ Yes, _____
Social Security #: _____-____-_____ Driver's License #: _____
Occupation: _____ Spouse's Name: _____
Number of children and their Ages: _____
Emergency Contact Name: _____ Phone #: _____

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** (10 being the worst pain; zero being no pain) rate you're above complaints:
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? _____ How did the injury happen? _____
When is the problem the worst? ☐ AM ☐ PM ☐ Mid-Day ☐ Late PM
How long does it last? ☐ It is constant ☐ On and off during the day ☐ On and off throughout the week
Condition(s) ever treated in the past? ☐ No ☐ Yes, by whom? _____ When? _____
How long were you under care? _____ What were the results? _____
Name of Previous Chiropractor: _____

*__PLEASE MARK__ the area on the diagram with the following letters to describe your 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? _____

LIST RESTRICTED ACTIVITY: **CURRENT ACTIVITY LEVEL**
_____: _____
_____: _____
_____: _____

Is your problem the result of ANY type of accident? ☐ No ☐ Yes
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:
_____
_____

PAST HISTORY

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

____ Broken Bone	____ Dislocations	____ Tumors	___ Disability
____ Heart Attack	____ Diabetes	____ Fractures	___ Rheumatoid Arthritis
____ Cancer	____ Osteoarthritis	____ Cerebral vascular	___ Other _____

PLEASE identify **PAST** and and **CURRENT** conditions that may be contributing to your present problem(s):

	WHEN	TYPE OF CARE RECEIVED	BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

SOCIAL HISTORY

Tobacco use: ☐ No ☐ Yes ☐ Quit How often? ☐ Daily ☐ Weekends ☐ Ocasionally
Alcoholic Beverages: ☐ No ☐ Yes How often? ☐ Daily ☐ Weekends ☐ Ocasionally
Recreational Drug use: ☐ No ☐ Yes How often? ☐ Daily ☐ Weekends ☐ Ocasionally

FAMILY HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes ☐ Unaware
If Yes: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Daughter(s) ☐ Son(s)
Have they ever been treated for their condition(s)? ☐ No ☐ Yes ☐ Unaware
Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes, _____

INITIAL NERVE SYSTEM PROFILE

Have you tested with high triglycerides or high cholesterol? ☐ No ☐ Yes Values? _____
Have you tested with high blood pressure? ☐ No ☐ Yes
Are you diabetic? ☐ No ☐ Yes
Have you been diagnosed as pre-diabetic or with metabolic syndrome? ☐ No ☐ Yes
How many days per week do you skip a meal? 0 - 1 - 2 - 3 - 4+
How many servings of fruit do you have on a given day? 0-1 2-3 4-5
How many servings of vegetables do you have on a given day? 0-1 2-3 4-5
Do you regularly drink 1 (or more per day) of any of the following?
☐ Soda ☐ Diet Soda ☐ Coffee ☐ Juice ☐ Milk ☐ Tea
Past spinal traumas? ☐ No ☐ Yes, _____
(Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, track and field, golf)
Childhood trauma? ☐ No ☐ Yes, _____
(Fall on your head, impact to your head, concussion, fall onto your back or tailbone, bilking accident)
Daily living trauma? ☐ No ☐ Yes, _____
(Work around the house, lifting, bending, woke up with a stiff neck, "back went out")

INITIAL NERVE SYSTEM PROFILE CONTINUED

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact - Side Impact - Rear Impact

Was treatment received? ☐ No ☐ Yes, _____

When was your most recent strain/stress at work? _____

Please describe the manner of the injury: _____

Was treatment received? ☐ No ☐ Yes, _____

Does your job require you to remain in long term stressful postures? ☐ No ☐ Yes, _____

(Example: all day seating, repeated lifting, long term computer use)

Please list any prescription & Non-Prescription drugs you take: _____

_____

_____

Please mark **P** for **Past**, **C** for **Currently** have or **N** for **Never** have had:

___ Headache	___ Pregnant	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vinson	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot/Knee Problems	___ Hearing Loss	___ Menstrual Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Problems
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gallbladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

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 very 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.

Regarding: Class IV Laser Therapy and Spinal Decompression:

I understand that I may also receive Class IV Laser Therapy and/or Spinal Decompression Therapy as part of my care. These non-invasive therapies are intended to reduce pain, decrease inflammation, and improve mobility. While generally well tolerated, possible side effects may include temporary soreness, stiffness, mild skin irritation, redness, warmth, or, in rare cases, increased discomfort. Protective eyewear will be provided during laser therapy. I acknowledge that no guarantees have been made regarding the results of these treatments and that any questions I have had have been answered to my satisfaction.

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

_____ _____/_____/_____

Patient or Authorized person's Signature Date

Activities of Daily Life

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition affects your ability to carry out routine activities in your daily life:

Bending	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
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
Recreation 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
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 to Standing	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (Can Do)	☐ Painful (Limits)	☐ Unable to Perform

Informed Consent for Diagnostic Imaging (X-Rays) and Pregnancy Disclosure

Females Only → Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

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

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

_____ _____/_____/_____

Patient or Authorized person's Signature Date

Scheduling Policy: Cancellations and Missed Appointments

I understand that scheduled appointments are reserved specifically for me. Appointments are scheduled with the office, not with a specific provider. Our office schedules patients based on availability, patient needs, treatment plans, and overall office scheduling. Patients may be seen by any of our qualified providers. All of our providers are trained to follow the same standards of care and work together as a team to provide consistent, quality care to our patients. If I need to cancel or reschedule, I agree to provide at least 24 hours' notice. In the event of an emergency, I understand that exceptions may be considered. Cancellations may be made by emailing us at contact@dochanson.com, calling 405-341-0494 (voicemail available if we are out of office), or texting us anytime at (580) 952-1410. If I am going to be late for my appointment, I understand that I must notify the office prior to my scheduled time, and the office will do its best to accommodate any necessary adjustments. I understand that missed appointments or cancellations made with less than 24 hours' notice may be subject to a fee. Failure to show up for a scheduled appointment without notice ("no-call, no-show") may also result in a fee and could affect future scheduling privileges. This policy helps us respect provider time and ensure availability for other patients in need of care .

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can access this information. We are required by law to protect your health information and provide you with this notice.

How We May Use Your Information: We may use and share your health information for

- Treatment (providing and coordinating your care)
- Payment (billing insurance or collecting payment)
- Health care operations (quality review, staff training, and clinic management)

We may also use or disclose your information when required by law, for public health reporting, or to prevent a serious threat to health or safety.

Your Rights: You have the right to

☐ Access and obtain a copy of your medical records ☐ Obtain a paper copy of this notice at any time

☐ Request corrections to your records ☐ Request restrictions on certain uses or disclosures

☐ Request confidential communications ☐ Receive a list of certain disclosures we have made

Our Responsibilities

We are required by law to maintain the privacy of your health information, provide you with this notice, and follow its terms. We may update this notice, and any changes will be available upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be penalized for filing a complaint.

I acknowledge that by signing below, I have received a copy of this Notice of Privacy Practices.

_____ _____/_____/_____

Patient or Authorized person's Signature Date

Please list below anyone whom you give legal access to your Medical Records/Accounting Information:

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

Our Office Policies

As a potential new patient, we feel it is important that you understand our office policies regarding how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. **Please read each policy carefully and initial stating there is no misunderstanding as to what you can expect as a patient of this practice and what we expect in return.**

____YOUR CARE - When a patient seeks chiropractic health care and we agree to provide that care it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Hanson Chiropractic is rendered primarily to minimize and reduce subluxations. The doctor uses Petabon Spinal Correction and activator adjustments through a myriad of techniques to accomplish this goal. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. **Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.**

____FIRST DAY GOALS - Prior to receiving care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxations while teaching patients what they need to do to maintain their health for a lifetime, in addition to being adjusted.

____PATIENTS REPORT OF FINDINGS - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a “Doctors Report”. **The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care will be discussed at that time we strongly urge new patients to invite their spouse or significant other to attend.** We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well they become infinitely supportive and helpful in making important decisions concerning treatment options. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for these findings we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it nor do we offer advice regarding treatment prescribed by others.

Our Office Policies - Continued

____PATIENT PRIVACY - It is important to understand that any conversations you have with the doctor could potentially be overheard by other patients. In order to maintain patient privacy, it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss, please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

____INSURANCE COVERAGE - All services that are billable to insurance will be submitted as outlined according to the care plan recommended by the doctor. Not all services are billable/covered by insurance companies. Payments for all charges are due in full until the verification is complete. All verifications are an estimate of coverage based on the information provided by the policy and not a guarantee of payment. Any balance remaining after payment is the responsibility of the patient.

____PAYMENTS - Based on the care prescribed by the doctor, payment options will be presented on your second visit during the Doctor's Report. We accept Cash, Check, Visa, Mastercard, American Express or Discover. Additionally, please let us know if you have a Health Savings Account or Health Reimbursement Account. Some payment arrangements do require that we maintain a valid card on file through our secure online processing service. Non-refundable items include but are not limited to: Supplements, BAXMAX, Footlevelers, Wobble Cushion, and open packages of Cervical Pillows, Lumbar Pillows, Spinal Moldings or Wedges. If you choose to discontinue care at any time, payment/refund for services rendered will be collected upon close of account. The account will not be closed until all outstanding insurance claims are processed by the patient's insurance company. If patient balance remains unpaid after two notices of payment due are sent. A fee of $10 will be charged for certified mail and collection services acquired to seek payment. Hanson Chiropractic utilizes Collections to acquire unpaid balances after 90 days of non-payment.

Over time it is our goal that you gain a greater understanding as to the purpose of chiropractic. Patients who are accepted for care have a unique opportunity to observe firsthand the positive results and benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you. Together, we can make affirmative changes in your life and the lives of those you care about.
If you have any questions regarding these policies, before submitting your Application for Care, please ask and we will be happy to discuss them with you further. We want you to make an informed decision about your applying for care at this office. Therefore, it is important for you to understand these policies, how our doctors practice chiropractic, and how we can help you receive the best care to achieve your goals for health.

I hereby acknowledge and assign to Hanson Chiropractic the rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by this provider. By paying my provider directly my insurance company or employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

My signature acknowledges that I can request a copy of these policies and understand this "Notice". I further acknowledge that any concerns regarding these "Policies" as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____
Patient's Name

_____ _____/_____/_____
Patient or Authorized person's Signature Date