



## PATIENT APPLICATION FORM

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.

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Patient Signature:

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Today's Date:

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

## PATIENT APPLICATION SURVEY

Name: \_\_\_\_\_ (Age) \_\_\_\_\_

Gender: M F

Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: S  
M D W

Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How were you referred to this office?  
\_\_\_\_\_

## PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:

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Is this visit related to an auto accident / work injury? Yes No If so, when:

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When did this condition begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Did it begin: Gradual Sudden  
Progressive Over time

What activities aggravate your symptoms?

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Is there anything, which has relieved your symptoms? Yes No  
Describe: \_\_\_\_\_

Type of Pain: Sharp Dull Ache Burn Throb Spasm  
Numb Tingling Shooting

Does the Pain Radiate into your: \_\_\_Arm \_\_\_Leg \_\_\_Does not radiate Is this condition getting worse? Yes  
No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25%  
10% Only with Activity

Does complaint(s) interfere with: \_\_\_Work \_\_\_Sleep \_\_\_Hobbies \_\_\_Daily Routine Explain:

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Have you experienced this condition before? Yes No If so, please explain:

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Who have you seen for this? \_\_\_\_\_ What did they do?

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How did you respond?

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## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? Yes No Who? \_\_\_\_\_ When?

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Reason for visits:

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How did you respond?

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Did your previous chiropractor take before and after x-rays? Yes No

Did you know posture determines your health? Yes No

Are you aware of any of your poor posture habits?

Yes No

Explain:

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Are you aware of any poor posture habits in your spouse or children?

Yes No

Explain:

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The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck? Yes No

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

## HEALTH LIFESTYLE

Do you smoke? Yes No How much?

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Do you drink alcohol? Yes No How much / week?

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Do you drink coffee? Yes No How many cups / day?

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Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other:

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What activities? Running Jogging Weight Training Cycling Yoga Pilates  
Swimming Other \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)?

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## HEALTH CONDITIONS

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body). Please check any health condition you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from subluxations, (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- q Neck Pain
  - q Pain into your shoulders arms/hands
  - q Numbness/tingling in arms/hands
- q Hearing disturbances
- q Weakness in grip
  - q Headaches
  - q Dizziness
  - q Visual disturbances
  - q Coldness in hands
  - q Thyroid conditions
- q Sinusitis
- q Allergies/Hay fever
- q Recurrent colds/Flue
- q Low Energy/Fatigue
- q TMJ/Pain/Click

Explain:

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#### THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...?

- q Heart Palpitations
- q Heart Murmurs
- q Tachycardia
- q Heart Attacks/Angina
- q Recurrent Lung Infections/Bronchitis
- q Asthma/Wheezing
- q Shortness Of Breath
- q Pain On Deep Inspiration/Expiration

#### THORACIC SPINE (MID BACK):

Postural distortions from subluxations (resulting from Forward Head Syndrome) in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience...?

- q Mid Back Pain
- q Pain Into Your Ribs/Chest

q Indigestion/Heartburn

- q Reflux
- q Nausea
- q Ulcers/Gastritis

q Hypoglycemia  
 q Tired/Irritable after eating or when  
 you haven't eaten for a while

**LUMBAR SPINE (LOW BACK):**

Postural distortions from subluxations in the low back (resulting from Forward Head Syndrome) will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience...?

- q Pain into your hips/legs/feet
  - q Numbness/tingling in your legs/feet
- q Coldness in your legs/feet
- q Muscle cramps in your legs/feet
- q Constipation / Diarrhea
- q Weakness/injuries in your  
 Hips/knees/ankles
- q Recurrent bladder infections
- q Frequent/difficulty urinating

- q Menstrual irregularities/cramping  
 (females)
- q Sexual dysfunction
- q Low back pain

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

Please list any medications currently taking and their purpose: \_\_\_\_\_

Please list all past surgeries: \_\_\_\_\_

Please list all previous accidents and falls: \_\_\_\_\_

**TERMS OF ACCEPTANCE**

When a person seeks chiropractic health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Courtley Chiropractic for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

## **CONSENT TO CARE**

I do hereby authorize Courtley Chiropractic to administer such care that is necessary for my particular case. This care may include a consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below. This includes those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are preexisting, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, \_\_\_\_\_, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (If under age 18) Parent's signature

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature Date

**Consent to x-ray:**

I hereby grant Courtley Chiropractic, P.A. permission to perform an x-ray evaluation if needed of \_\_\_\_\_. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature (parent if minor) Date

**Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature Date

INSURANCE INFORMATION

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*(If under age 18) Parent's signature*



## Acknowledgement of Receipt of Notice of Privacy Practices

149 Kelsey Drive, Suite 1502  
Lenoir City, TN 37772  
865-986-8088

**I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

- q The right to review the notice prior to signing this consent,
- q The right to object to the use of my health information for directory purposes, and
- q The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

### **Tennessee Chiropractic Association Authorization**

**Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Tennessee Chiropractic Association (TCA). This disclosure will be made if we need the TCA's assistance to receive reimbursement for your services or, we need the TCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.**

By signing this form you are giving us authorization to send the TCA this information. You are also giving the TCA authorization to re-disclose your information to the party responsible for the payment of your services, the TCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

### **Appointment Reminders and Health Care Information Authorization**

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message

will be left on our answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature:

Date:

If not signed by the patient, please indicate relationship.

q Parent or guardian of minor patient

q Guardian or conservator of an incompetent patient

q Beneficiary or personal representative of deceased patient

Name of Patient:

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***For Office Use Only:***

Signed form received by:

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Acknowledgement refused: (Efforts to obtain/ Reasons for refusal)

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