
2105 E. Clairemont Ave., Eau Claire, WI 54701
Phone (715)835-9514 Fax (715)835-2602

# 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 to assist in determining if you are a chiropractic case. Please feel free to ask any questions if you need assistance. We look forward to serving you.

_____
Patient Signature

_____ _____
Today's Date File #

**Stucky Chiropractic Center, 2105 E. Clairemont Avenue, Eau Claire, WI 54701**

**Phone (715)835-9514 Fax (715)835-2605**

Date: _____ # PATIENT APPLICATION SURVEY

First Name: _____ Middle Initial: ___ Last Name: _____ Age: _____ Birth Date: ____ / ____/ ____

Gender: M F Height:_____Weight:_____Social Security #: _____ - _____ - _____ Marital Status: S M D W

Race/Ethnicity: □ White/Caucasian □ African American □ Asian/Hmong □ Native American □ Hispanic/Latino

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Occupation: _____ Employer Name: _____

Language: □ English □ Spanish □ Chinese □ Other:_____Names and Ages of Children:_____

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: _____

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

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

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: _____

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

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

## EXPERIENCE WITH 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 you know posture determines your health? □ Yes □ No

Are you aware of any of your poor posture habits? □ Yes □ No

Explain: _____

Are you aware of any poor posture habits in your spouse or children? □ Yes □ No

Explain: _____

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

# HEALTH LIFESTYLE

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

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Have you ever smoked? Yes No Do you currently Smoke? Yes No How much? _____

If yes would you like information on quitting? _____

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

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

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

## 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…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ High Blood Pressure
- ❑ Recurrent colds/Flu
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking
- ❑ Allergies/Hay fever

Explain: _____

## 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…?

- ❑ Heart Palpitations
- ❑ Heart Murmurs
- ❑ Tachycardia
- ❑ Heart Attacks/Angina
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ 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…?

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Hypoglycemia
- ❑ Tired/Irritable after eating or when you haven't eaten for a while
- ❑ Diabetes

## 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…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions or allergies not mentioned: _____

Please list any medications currently taking and their purpose: _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

**Stucky Chiropractic Center, 2105 E. Clairemont Avenue, Eau Claire, WI 54701**

**Phone (715)835-9514 Fax (715835-2605**

## GOALS FOR MY CARE

Indicate all statements that apply to you:
□ I have a specific health concern.
□ I want to ensure that my health concerns do not become an ongoing problem.
□ I am interested in learning how to improve my quality of life.
Are you healthier now than you were 1 year ago? □ Yes □ No
If yes, what did you do to accomplish this?

_____

Is it your goal to be healthier 1 year from now than you are today? □ Yes □ No

Do you have a plan on improving your health? _____

_____

Have you ever been advised on lifestyle choices for good health? □ Yes □ No

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it.

An **adjustment** is the specific application of forces by hand or instrument to facilitate the body's correction of vertebral subluxation.

**Health** is a state of optimal physical, mental and social well being, not merely the absence of disease/symptoms.

**Vertebral Subluxation** is a misalignment of one or more of the joints of the spine. This may or may not cause pain. This also will result in alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to heal and achieve optimal health.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.
OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. One method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statement.

Any questions regarding the Doctor's objectives pertaining to care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature_____ Date_____

CA Signature_____ Date_____

# AUTHORIZATION FOR CARE

I hereby authorize the Doctor(s) to work with my condition through the use of spinal adjustments, as he or she deems appropriate. **I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.** This office will provide insurance billing services for you, if you so desire, as a courtesy. **It is your legal responsibility to pay any deductible amount, co-insurance and or any other balances not paid by your insurance carrier.** The Doctor(s) will not be held responsible for any medical diagnosis**. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable.** I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Stucky Chiropractic Center, S.C. will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Stucky Chiropractic Center, S.C. will be credited to my account on receipt.

Patient or Guardian Signature_____ Date_____

# NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days of a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Print)_____

Patient or Guardian Signature_____ Date_____

CA Signature_____ Date_____