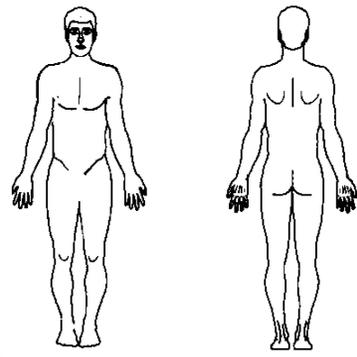
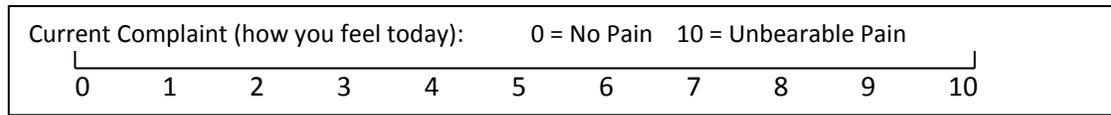


Patient Name: _____ Nickname: _____ Birthdate: _____
 Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____
 Home#: _____ Cell#: _____ Work#: _____
 Occupation: _____ Employer: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____
 Marital Status: M S W D Spouse Name: _____ Spouse's Occupation: _____
 Do you have children? Y N How many? _____ Preferred Language: English Other: _____
 Race: White Black/African American American Indian Asian Hispanic/Latino Multi-Racial Other Race
 Referred By: Patient/Doctor _____ Event Radio/TV Print Media Insurance Internet
 Emergency Contact: _____ Emergency Phone Number: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Headache Neck Pain Mid-Back Pain Low Back Pain Other _____ **Mark an X on the picture where you have pain**
 Is this? Work Related Auto Related N/A Date Problem Began: _____



How often are your symptoms present? (Occasional) 0-25% 26-50% 51-75% 76-100%

In general how is your overall health right now: Excellent Very Good Good Fair Poor

Please check all of the following that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Menstrual Problems/Hormones | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Recent Fever/Rheumatic Fever | <input type="checkbox"/> Thyroid <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Problems/Kidneys/Bladder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> High <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Currently Pregnant, # Weeks _____ | <input type="checkbox"/> Hand or Wrist Pain |
| <input type="checkbox"/> Blood Clots/Stroke (Date): _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/> HIV/Aids/Blood Infections |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Pain Unrelieved by Position or Rest | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Taking Birth Control Pills | <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Dizziness/Fainting/Concussion | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Neck Pain or spasms |
| <input type="checkbox"/> Numbness in Groin/Buttocks | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Neuritis/Numbness/Neuro Disorders |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> M.S./Muscular dystrophy |
| <input type="checkbox"/> Osteoporosis/Arthritis | <input type="checkbox"/> Back Pain Sciatica | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Epilepsy/Seizures/Convulsions | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Liver/Hepatitis/Cirrhosis |
| <input type="checkbox"/> Other Health Problems (Explain) _____ | <input type="checkbox"/> Heart | <input type="checkbox"/> Deep Vein Thrombosis |
| | <input type="checkbox"/> Lungs/Asthma/Bronchial | <input type="checkbox"/> Surgeries: _____ |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Shortness of Breath | |
| | <input type="checkbox"/> Fibromyalgia | |

Have you seen a chiropractor this year? Yes No If yes, who? _____ How many visits? _____
 Are you currently being treated under home health care? Yes No If yes, who? _____

Family Medical Doctor: _____ Date of Last Visit: _____ M _____ D _____ Y

Family History (Mother/Father/Brother/Sister) please check/circle all of the following that apply to you:

- Heart Disease-M / F / B / S High Blood Pressure- M / F / B / S Diabetes- M / F / B / S Circulation Problems- M / F / B / S
 Cancer-M / F / B / S Rheumatoid Arthritis/Arthritis-M / F / B / S Stroke-M / F / B / S Neurological Disorder-M / F / B / S

Smoking Status: Current every day smoker Occasional smoker Former Smoker Never Smoked

ALLERGIES (please describe reaction such as hives, throat swelling, GI upset)	Immunization Record (list date of last vaccination)	
Allergic to: <input type="checkbox"/> Antibiotic <input type="checkbox"/> Tape <input type="checkbox"/> Betadine (Iodine) <input type="checkbox"/> Latex	Flu	Hepatitis
<input type="checkbox"/> Allergies to Medications (please list):	Pneumonia	Tetanus
<input type="checkbox"/> No Known Allergies	Other: _____	

Patient Signature: _____ **Date:** _____

Medications Currently Taking (including OTC, herbals, patches, nasal sprays, etc.) *If you have a list, please give to the front desk			
Medication & Dosage (e.g. 25mg)	Directions (e.g. 2x daily, as needed)	Started taking (e.g. 2010)	Prescribing Doctor:
<input type="checkbox"/> Not taking any medications			

CONSENT TO TREATMENT

I hereby request and consent to the performance of medical, osteopathic, chiropractic, podiatric medicine and surgery, nutritional and other procedures, including but not limited to various modes of physical therapy, massage therapy, joint manipulation, medicine, injections, minor surgical procedures, splinting, casting, wound treatment, and diagnostic tests, on me/child (or the patient named below, for whom I am legally responsible) by the licensed physician(s) and/or other healthcare providers who now or in the future work at the clinic or the office listed above or any other office or clinic. Before any procedures occur, I understand I will have the opportunity to discuss with the physician(s) and/or other healthcare provider(s) and/or with other office or clinic personnel the nature and purpose of the treatments and other procedures. I understand that results are not guaranteed. I understand and am informed that, in the practice of medicine, chiropractic, podiatric medicine and surgery, physical therapy and other applicable methods of treatment, there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations, sprains and infections. I do not expect the physician(s) or other healthcare provider(s) to be able to anticipate and explain all the risks and complications, and I wish to rely upon the physician(s) and/or other healthcare provider(s) to exercise judgment during the course of the procedure which the physician(s) and/or other healthcare provider(s) feel at the time, based upon the facts then know to him or her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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 condition(s) for which I seek treatment. I also understand if I am not given the opportunity to discuss procedure/treatment, I may withdraw consent at any given time for any reason. _____ Initials

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Apple Healthcare Group’s Notice of Privacy Practices. This notice describes how Apple Healthcare Group may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. _____ Initials

RIGHT TO SUBMIT BILLING

Apple Healthcare Group will file your claims with your insurance company as a courtesy to you. You will be responsible for your deductible and/or co-payments at the time of treatment. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial. As a convenience to our patients, we offer timely and affordable payment plans for each patient that has a care plan for them for their individual condition. This allows patients to receive the care they need while minimizing the stressors of money. Any charges incurred in debt collection will be paid by the patient until all balances are cleared. _____ Initials

CONSENT TO EMAIL/TEXT USAGE FOR APPOINTMENT REMINDERS & OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, electronic statements, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders, statements and other health communications/information at that email or text address from the practice. I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/electronic statements/health information unless I request a change in writing. *The practice does not charge for this service, but standard text messaging rates apply as provided in your wireless plan (contact your carrier for pricing plans & details).* _____ Initials

Email address: _____

Cell Phone: _____

IF PATIENT IS A MINOR, YOU MUST COMPLETE THE SECTION BELOW:

Subscriber/Guarantor Name:	Social Security Number:	Date of Birth:
Subscriber/Guarantor’s Address if different from patient:	Phone Number if different from patient:	Relationship to Patient:
Employer:	Employer Address:	Employer Phone Number:

Do you have a living will? Yes No

Patient Name (please print): _____ Date: ____/____/____

Patient Signature: _____ Date: ____/____/____

Guardian’s Signature (if applicable): _____ Date: ____/____/____