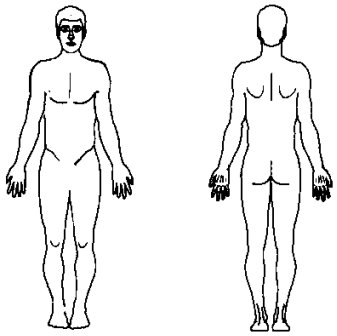
North/Central Office: 4307 Ball Camp Pike ● Knoxville, TN 37921 ● t 865.524.1234 ● f 865.524.2169
West Office: 312 Prosperity Drive, Ste. 101 ● Knoxville, TN 37923 ● t 865.691.3155 ● f 865.694.8093
Sutherland Office (In Cherokee Mills/Square One):
2270 Sutherland Ave ● Knoxville, TN 37919 ● t 865.524.1234 ● f 865.524.2169
www.applehealthcaregroup.com

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 _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A Date Problem Began: _____

Mark an X on the picture where you have pain



Current Complaint (how you feel today): 0 = No Pain 10 = Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

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:

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

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: ☐ Antibiotic ☐ Tape ☐ Betadine (Iodine) ☐ Latex	Flu	Hepatitis
☐ Allergies to Medications (please list):	Pneumonia	Tetanus
☐ No Known Allergies	Other:	

Patient Signature: _____ **Date:** _____

For Office Use Only: MRN#: _____

Revised: 12.24.19

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:**
☐ 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: _____

Do you have a living will? ☐ **Yes** ☐ **No**

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

Patient Signature: _____ Date: _____/_____/_____

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

Subscriber/Guarantor Name:	**Relationship to Patient:**	**Date of Birth:**
Subscriber/Guarantor's Address if different from patient:	**Phone #(if different from patient):**	

Guardian's Signature (if applicable): _____ Date: _____/_____/_____

For Office Use Only: MRN#: _____

Revised: 12.24.19