NEUROPATHY RELIEF APPLICATION FORM

Name: _____ (Age) _____ Gender: M F

Home Address: _____Home Phone: _____

City, State, Zip: _____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Marital Status: S M D W Occupation: _____

Employer Name: _____ Spouses Name: _____

How did you hear about our office? _____

In order of importance, list the health problems you are most interested in getting corrected:

1. _____ How long have you had this problem: _____
2. _____ How long have you had this problem: _____
3. _____ How long have you had this problem: _____
4. _____ How long have you had this problem: _____

Is there a certain time of the day any of these problems are better or worse? _____

_____

Is your balance / walking ability affected by your condition? If yes, please describe: _____

_____

Please circle the things you have used for these problems: *Gabapentin Neurontin Lyrica Cymbalta Creams Pain Meds Physical Therapy Aleve Tylenol Ibuprofen Motrin Massage Therapy Chiropractic Injections*

What do you think is causing your problem? _____

Name of all doctors you have seen for these problems and treatment you have received: _____

_____

Over the past several months / weeks have your symptoms: *Improved Worsened Stayed the same*

List anything that makes your condition worse: _____

Lista anything that makes your condition better: _____

How would you describe your symptoms? Please circle ALL that apply

Aching Pain Numbness Hot Sensation Cramping Stabbing Pain Tingling Swelling
Throbbing Pain Sharp Pain Dead Feelings Burning Pain Tiredness Tired Coldness
*Electric Shocks Pins & Needles Other:*_____

Is this condition and/or symptoms interfering with any of the following? Please circle ALL that apply

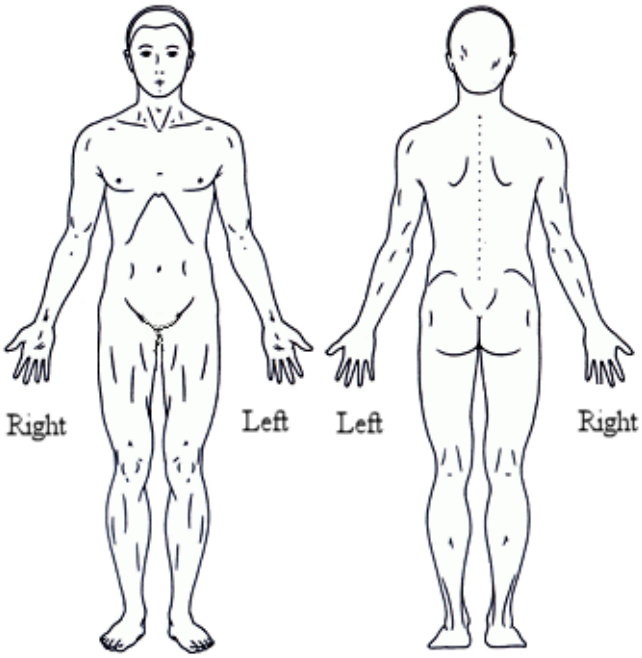
Sleep Work Daily Activities Walking Standing Recreational Activities

Do you SMOKE? *Yes No If yes, how many cigarettes daily?* _____

Do you DRINK? *Yes No If yes, how many drinks per week?* _____

Do you exercise regularly? *Yes No If yes, please describe how often:* _____

Using the symbols below, mark on the pictures where you feel your symptoms.



Numbness = = =

Dull Ache OOO

Burning XXX

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^

Please check ALL that apply:

	Foot Pain		Spinal Stenosis		Spinal Arthritis		Pacemaker / Defibrillator
	Foot Numbness		Bulging Disc		Arthritis in hands		Vascular Problems
	Hand Pain		Herniated Disc		Arthritis in feet		Plantar Fasciitis
	Hand Numbness		Degenerative Disc		Sciatica		Excessive thirst
	Low Back Pain		Leg Pain		Pinched Nerve		Excessive urination
	Neck Pain		Leg Numbness		Poor Wound Healing		Foot Surgery
	Diabetes		High Cholesterol		High Blood Pressure		Vascular Problems
	Implanted Cord		Bladder Stimulator		Morton's Neuroma		Chemotherapy
	Joint Replacement:				Cancer:		
	Uncontrolled Blood Sugar				Other:		

Please list any health conditions you may be experiencing that are not mentioned… _____

_____

Are you under medical care for any condition(s)? No Yes, which condition(s)?_____

_____

_____

How would you rate your symptoms? *(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)*

If you had to accept some level of symptoms after completion of treatment, what would be an acceptable level for you? *(none) 0 1 2 3 4 5 6 7 8 9 10 (worst)*

ON A SCALE OF 1-10, HOW MOTIVATED ARE YOU IN GETTING HELP FOR YOUR CONDITION? (please circle)

Least Motivated 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. *Most Motivated*

List all nutritional supplements (i.e. vitamins, minerals, herbs)?

Please list any medication you are currently taking and why?

MEDICATION	REASON FOR THE MEDICATION

List ALL allergies / sensitivities to medication, food, and other items here:

Item you react to:	Reaction

What are your goals? What is it you are looking to accomplish? (please be specific as possible)

_____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name_____

Signature _____ Date:_____

In Case of Emergency

Name_____ Relationship_____

Home Phone ( ) _____Cell Phone ( ) _____

Pregnancy Release

This is to certify that I am not pregnant. By signing below the above doctor and his associates have my permission to perform/request 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 CARE / TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Health & Wellness facility we have one main goal, to support the healthy function of the body and promote health and healing. 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.

I do hereby authorize the doctors of Power of LIFE Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other 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 D.C. to administer the necessary treatments to help restore and support healthy function of my body. I have had an opportunity to discuss with the doctor the nature and purpose of my treatment and any other procedures related to my health care. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; 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 and/or staff for all services rendered. I understand that any discounts applied to my account are plan discounts and if care is terminated early I am subject to forfeiting any and all discounts and will be billed for all services received at their full rate.

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.

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 the correction of vertebral subluxation and any future treatment for which I seek.

Signature_____ Date _____
(If under age 18) Parent's signature

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Name: _____

Patient Birth Date: _____

We at Power of Life, LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have access to the HIPAA Notice of Privacy Practice document and can request access at any time for my review.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient