Date:______________

PATIENT APPLICATION

Name:____ Age:____ Gender:_____________________

Home Address:_____________________________________ Home Phone:____________________________

City, State, Zip:__________________________________ Cell Phone:______________________________

Email: ____ O ctkcn'Uvcwu<aaaaaaaaaaaaaaaaaaaaaaaaaa"

Birth Date:_____________________ Spouse Name:____________________________

Names of Children: ______________ ______________ ______________ _____________ ______________

Ages of Children: ___ ___ ___ ___ ___

Employer: _____________________________ Type of work: ________________________________

How were you referred to this office? Friend/Family Insurance Google Search Phone Book

Referral name: _____________ __________

PURPOSE OF THIS VISIT

Reason for this visit: ____

Is this related to an auto or work related accident? Y N

What activities aggravate your symptoms: ____

Has anything relieved your symptoms: Y N

Describe: ____

Have you experienced this condition before? Y N

Have you seen anyone for this condition? Y N

Who? ____

What did they do? ____

How did you respond? ____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? Y N Who? ____

When? _________________________________ Reason for visit? ____________________________________

How did you respond? ____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 3 MONTHS:

GENERAL
- ☐ Lethargy / Weakness
- ☐ Recurring Fever
- ☐ Recent weight loss or gain

HEENT
- ☐ Headaches or migraines
- ☐ Eye or vision problems
- ☐ Ear or hearing problems
- ☐ TMJ problems

CARDIOVASCULAR
- ☐ Chest pain or tightness
- ☐ Shortness of breath
- ☐ Swelling of feet or hands
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol or triglycerides
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Varicose veins
- ☐ Excessive bruising

RESPIRATORY
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Breathing or lung problems

GASTROINTESTINAL
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Bloating/Cramping
- ☐ Heartburn
- ☐ Change in bowel habits
- ☐ Food sensitivities

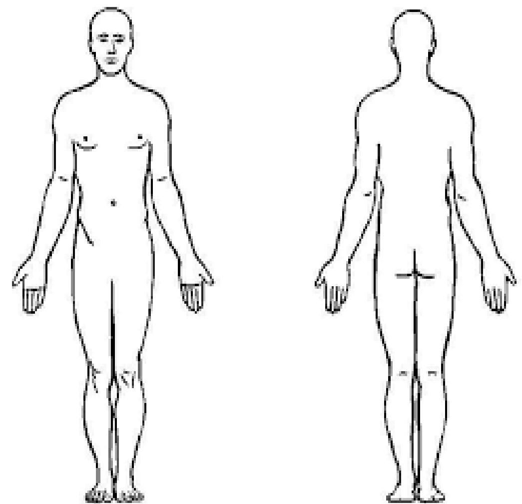
NEUROLOGICAL
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory loss
- ☐ Poor balance
- ☐ Numbness or tingling
- ☐ Pins and needles
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Head injury
- ☐ Anxiety and/or panic
- ☐ Depression
- ☐ Sleeping issues
- ☐ Weak muscles
- ☐ Loss of smell or taste
- ☐ Temporary loss of vision
- ☐ Difficulty concentrating

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint pain or swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Cramping
- ☐ Fractures
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot / ankle pain
- ☐ Shoulder problems
- ☐ Elbow / wrist pain

PSYCHIATRIC
- ☐ Insomnia
- ☐ Difficulty concentrating
- ☐ Memory loss/confusion
- ☐ Depression
- ☐ Anxiety
- ☐ Agitation/Irritability

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Change in appetite
- ☐ Hair changes

ALLERGIES
- ☐ Seasonal
- ☐ Medication
- ☐ Food



Please outline on the diagram the areas of discomfort

Date:_______________________________

HIPPA Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

B. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**
2. **Payment**
3. **Health Care Operations**
4. **Appointment Reminders**
5. **Treatment Options**
6. **Health-Related Benefits and Services**
7. **Release of Information to Family/Friends**
8. **Disclosures Required by Law**

If you wish to receive a more detailed copy of this notice, please ask the front desk.

Name:______________________________________ Date:_________________

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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 further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name:____ Date:__________________

Swink Chiropractic Wellness

Dr. Ryan Swink DC