Application for Care at Tinker Family Chiropractic

Today's Date: _____ HRN: _____

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Cell Phone: _____ Home Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____ Relationship: _____

HISTORY OF PHYSICAL COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

QUADRUPLE VISUAL ANALOG SCALE

On a scale of **1** to **10**, with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling*** *the number*.
If you have more than one symptom, please label each one accordingly.

For example: 0 - (1) - 2 - 3 – (4) – 5 – 6 – (7) – 8 – 9 – 10
Headaches Neck Low Back

What is your pain **RIGHT NOW**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your **TYPICAL or AVERAGE** pain? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your pain level **AT ITS BEST**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

What is your pain level **AT ITS WORST**? 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? ☐ *AM* ☐ *PM* ☐ *mid-day* ☐ *late PM*

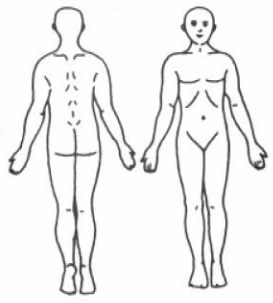
How long does it last? ☐ *It is constant* ☐ *I experience it on and off during the day* ☐ *It comes and goes throughout the week*

How did the injury happen?_____ Is your problem a result of ANY type of accident *(YES or NO)*

Have you been treated for this in the past? ☐*No* ☐ *Yes* **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ *(☐ I've never been to a chiropractor)*



PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness
S = Sharp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Patient's Name: _____ HR#: _____ Date: __/__/__

DAILY ACTIVITIES: Effects of Current Conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐Painful (Limits)	☐ Unable to Perform

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain / stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long term stressful postures?_____

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past:

- Collision, quick burst, or repetitive motion sports (football, wrestling, basketball, baseball, soccer, tennis, golf, track/field)?

(YES or No) Please describe: _____

-Trauma as a child? (fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident)?

(YES or No) Please describe: _____

- Work around the house – lifting, bending, woke up with stiff neck, "back went out"?

(YES or No) Please describe: _____

- Any other traumas not listed above? _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Patient's Name: _____ **HR#:** _____ **Date:** ___/___/___

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ ADD/ADHD	___ Digestive Problems	___ Stroke
___ Neck Pain	___ Pain w/Cough/Sneeze	___ Learning Disability	___ Colon Trouble	___ Cerebral Vascular Disease
___ Jaw Pain, TMJ	___ Dislocations	___ Depression	___ Diarrhea/Constipation	___ Chest Pain
___ Shoulder Pain	___ Swollen/Painful Joints	___ Anxiety	___ Ulcers	___ Heart Attack
___ Upper Back Pain	___ Rheumatoid Arthritis	___ Mood Changes	___ Heartburn	___ Heart Problems
___ Mid Back Pain	___ Dizziness	___ Irritable	___ Menopausal Problems	___ High Blood Pressure
___ Low Back Pain	___ Loss of Balance	___ Trouble Sleeping	___ Menstrual Problem	___ Low Blood Pressure
___ Hip Pain	___ Fainting	___ Double Vision	___ PMS	___ High Cholesterol/Triglycerides
___ Back Curvature	___ Convulsions/Epilepsy	___ Blurred Vision	___ Prostate Problems	___ Diabetes/Prediabetes
___ Scoliosis	___ Tremors	___ Ringing in Ears	___ Impotence/Sexual Dysfun.	___ Difficulty Breathing
___ Osteoarthritis	___ Frequent Colds/Flu	___ Hearing Loss	___ Kidney Problems	___ Lung Problems
___ Fractured Bone	____ Disability	___ Skin Problems	___ Gall Bladder Problems	___ Asthma
___ Foot/Knee Problems		___ Eating Disorder	___ Liver Trouble	___ Allergies
___ Numb/Tingling arms, hands, fingers		___ Tumors	___ Hepatitis (A,B,C)	___ Sinus/Drainage Problem
___ Numb/Tingling legs, feet, toes		____ HIV/AIDS	___ Cancer (Type:_____)	

___ Other conditions/diagnoses not listed: _____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Does anyone in your family suffer with the same condition? ☐ *No* ☐ *Yes* **If yes, whom?** _____

Have they ever been treated for their condition? ☐ *No* ☐ *Yes* ☐ *I don't know*

Any other hereditary conditions the doctor should be aware of. ☐ *No* ☐ *Yes*: _____

List Prescription & Non-Prescription drugs or supplements you take:_____

_____

_____

I hereby authorize payment to be made directly to Tinker Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Tinker Family Chiropractic or any and all services I receive at this office.

_____ **Patient or Authorized Person's Signature**

_____ - _____ - _____ **Date Completed**

_____ **Doctor's Signature**

_____ - _____ - _____ **Date Form Reviewed**

Patient's Name: _____ HR#: _____ Date: ___/___/___

Have you had COVID-19? *Yes or No* If yes, when? _____

Have you received one or more COVID-19 vaccines? *Yes or No* If so, how many & which one? _____

Do you smoke? *☐ No ☐ Cigars ☐ Pipe ☐ Cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never ☐ Quit on _____*

Do you drink alcoholic beverages? *☐ Daily ☐ Weekends ☐ Occasionally ☐ Never*

Do you use recreational drugs? *☐ Daily ☐ Weekends ☐ Occasionally ☐ Never*

INITIAL NUTRITIONAL PROFILE

Do you eat breakfast daily from Monday to Friday? *YES or NO*

How many days per week do you skip one meal? *(0) (1) (2) (3) (4+)*

How many fast food, refined foods, or pre-pared meals do you eat per week? *(0) (1-3) (4-6) (7+)*

How many servings of fruit do you have on a given day? *(0-1) (2-3) (4+)*

How many servings of vegetables do you have on a given day? *(0-1) (2-3) (4-5)*

Do you regularly drink (1 or more per day) any of the following? *(circle all that apply)*

Diet Soda Coffee Juice Milk Soda Alcohol

INITIAL FITNESS PROFILE

How many times per week do you exercise? _____

Cardiovascular ___Hours ___Days/Wk Weight Training ___Hours ___Days/Wk

Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____What is your current weight? _____

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? *YES or NO*

Have you ever noticed mold growing in your home or your place of work? *YES or NO*

Does your home, work, school, or car have damp or mildew smell? *YES or NO*

Have you received a full standard profile of vaccinations? *YES or NO*

Do you receive yearly flu shots? *YES or NO* How many flu shots have you received? _____ (estimate)

Have you been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? *YES or NO*

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? *YES or NO*

INITIAL STRESS PROFILE

Do you average less than 7 hours of sleep per night? *YES or NO*

Do you ever take pills to go to sleep or relax? *YES or NO*

Do you often feel short on time and procrastinate on projects? *YES or NO*

Do you experience feelings of anxiety about completing tasks? *YES or NO*

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? *YES or NO*

Do you rely more on your memory than a planner and action list to get things done? *YES or NO*

Do you take time to pray, meditate, or visualize on a regular basis? *YES or NO*

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** **_____**

Looking out 6-12 months, what would your ultimate health goal be? _____

_____

We are here to help you reach your God-given potential, in Health and in Life!! We look forward to helping you reach your health goals!

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Tinker Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

JDD,DC 5/2011

TINKER FAMILY CHIROPRACTIC
Release of Information

Your privacy is very important to us, please list any person/persons to whom we may discuss your chiropractic care, financial, and or any issues dealing with your health.

Name_____ Relation _____

Phone # _____

Name_____ Relation _____

Phone #_____

Name_____ Relation _____

Phone #_____

The following names above have permission to speak with the doctors and/or staff concerning my care and/or finances.

Signature_____ Date_____

Tinker Family Chiropractic's Office Policies

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two-page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

Tinker Family Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Tinker Family Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____	_____	_____
Patient's Name	DOB	HR#
_____	_____	
Patient signature	Date	
_____	_____	
Witness	Date	

OUR OFFICE POLICIES

Welcome to Tinker Family Chiropractic!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Tinker Family Chiropractic is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Diversified Full Spine, Thompson, Activator, and Arthrostim. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Tinker Family Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Tinker at (615) 948-3790 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201