PURE ALIGNMENT
CHIROPRACTIC

APPLICATION FOR CARE AT PURE ALIGNMENT CHIROPRACTIC - PREGNANCY

PRACTICE MEMBER HEALTH REVIEW: Today's Date: ___ / ___ / ____ PMID#: _____

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

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

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Carrier: _____

E-mail Address: _____ Preferred Method of Contact: ☐ Email ☐ Home Phone ☐ Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Driver's License Number: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer: _____

Number of children, names, and ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

Previous Chiropractic Care: ☐ No ☐ Yes When: _____ Where: _____

Whom may we thank for referring you to this office? **_____**

HISTORY of COMPLAINT:

Please identify the condition(s) that brought you to this office:

Primary: _____

Secondary: _____

Third: _____

Fourth: _____

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*****:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 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 **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

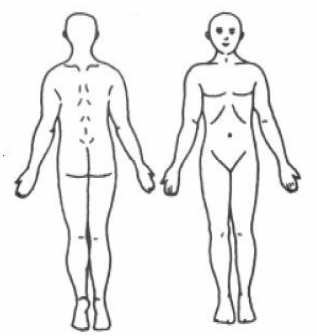
Have you suffered from this before? ☐ No ☐ Yes **If yes,** how many times? _____ When was the last episode? _____

Have you tried other treatments? ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____

Who provided it: _____ How long ago: _____

Were the results ☐ Favorable ☐ Unfavorable → please explain: _____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Is your problem the result of ANY type of injury/accident? ☐ No ☐ Yes

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY:

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

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular/Stroke ___ Other serious conditions: _____

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 →			

SOCIAL HISTORY:

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes How often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

I hereby authorize payment to be made directly to Pure Alignment 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 Pure Alignment Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Practice Member or Authorized Person's Signature **Date**

Reviewed by Dr. Katherine Burtis, D.C.

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ☐ No ☐ Yes
If yes whom: ☐ grandmother ☐ grandfather ☐ mother ☐ father ☐ sister(s) ☐ brother(s) ☐ son(s) ☐ daughter(s)
Have they ever been treated for their condition? ☐ No ☐ Yes ☐ I don't know

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

Confidential Member Information – Family Health History
This form is to assist the doctor by providing past health history information for their review

****PLEASE CHECK THE APPROPRIATE BOXES BELOW****

Health Concern	Spouse	Son	Daughter	Mother	Father
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD / ADHD					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DIABETES					
DIGESTIVE ISSUES					
DISC ISSUES					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

_____ _____ - _____ - _____

Practice Member or Authorized Person's Signature **Date**

ACTIVITIES OF LIFE:

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

____ ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

_____ _____ - _____ - _____

Practice Member or Authorized Person's Signature **Date**

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

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

PREGNANCY:

Provider Name: _____ ☐ Midwife ☐ Obstetrician
Name of Provider's Practice/Group: _____ City: _____ State: _____
Provider Phone Number: _____ Ultrasounds during pregnancy? ☐ No ☐ Yes
Estimated Date of Delivery: _____ Gestational Age: _____ weeks Sex of baby: ☐ M ☐ F
Baby positioning: _____ Verified by: _____ Baby name: _____

During your pregnancy, have you experienced any of the following:

Falls? ☐ No ☐ Yes
Motor Vehicle Accident? ☐ No ☐ Yes
High Blood Pressure? ☐ No ☐ Yes
Diabetes? ☐ No ☐ Yes
Anemia? ☐ No ☐ Yes
Morning Sickness? ☐ No ☐ Yes
Indigestion? ☐ No ☐ Yes
Seizures? ☐ No ☐ Yes
Swollen ankles? ☐ No ☐ Yes
Thyroid problems? ☐ No ☐ Yes
Heart Problem? ☐ No ☐ Yes
Back pain? ☐ No ☐ Yes
Public symphysis discomfort? ☐ No ☐ Yes
Abnormal Bleeding? ☐ No ☐ Yes
Hospitalization? ☐ No ☐ Yes
Any other illnesses? ☐ No ☐ Yes
Any other complications/risk during this pregnancy? _____

During your pregnancy, have you used any of the following?

Tobacco? ☐ No ☐ Yes
Alcohol? ☐ No ☐ Yes
Prescription medication? ☐ No ☐ Yes
If yes, please list: _____
Over-the-counter medication? ☐ No ☐ Yes
If yes, please list: _____

Number of previous pregnancies and ages of children: _____
Complications during previous pregnancies/births? ☐ No ☐ Yes
If yes, please explain: _____

Reviewed by Dr. Katherine Burtis, D.C.

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pai n, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855 -862, 1993, w ith permission from Elsevier Science.

INFORMED CONSENT

REGARDING Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations.
Vertebral subluxation is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.
A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that practice members may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Pure Alignment Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. Having this knowledge, I knowingly authorize chiropractic care with Pure Alignment Chiropractic by any means, method, and or techniques, the doctor deems necessary at any time throughout the entire clinical course of my care.

Witness Initials

_____ ____/____/____

Practice Member or Authorized Person's Signature Date

Reviewed by Dr. Katherine Burtis, D.C.

REGARDING Parental Consent for Minor Practice Member

Practice Member Name: _____ Practice Member Age: _____ DOB: _____

Printed name of person legally authorized to sign for

Practice Member: _____

Signature: _____

Relationship to Practice Member: _____

In addition, by signing below, I give permission for the above named minor practice member to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Practice Member: _____

Signature: _____

Relationship to Practice Member: _____

REGARDING Non-Pregnancy Verification

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 hereby notify all concerned that I neither suspect nor know positively at this time that I may be pregnant. I release this clinic from any and all damages arising from any and all procedures of diagnostic x-rays or care nature with reference to the possibility of pregnancy.

Witness Initials

_____ ____/____/____

Practice Member or Authorized Person's Signature Date

PURE ALIGNMENT 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.

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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 upcoming 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. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.** (Please note: x-rays are utilized in this office to locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor does not diagnose or treat medical conditions; however, if any abnormalities are noted, we will bring it to your attention so you can seek proper medical advice.

COMPLAINTS

If you wish to make a formal compliant about how we handle your health information, please call Dr. Katherine Burtis at (386)-473-5926. If she is unavailable, you may make an appointment with our front desk coordinator 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 may submit a formal complain to:

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

I have received a copy of PURE ALIGNMENT CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's 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.

Practice Member's Name	DOB	HR#
Practice Member's Signature	Date	
Witness	Date	

Reviewed by Dr. Katherine Burtis, D.C.