

Whom may we thank for referring you to this office? → \_\_\_\_\_

### APPLICATION FOR CARE AT MAX LIVING

Today's Date: \_\_\_\_\_

#### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_ Male  Female   
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Marital Status: M S D W Name of Spouse or Significant Other: \_\_\_\_\_ # of Children: \_\_\_\_\_  
Name & # of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age(s) of Children: \_\_\_\_\_  
Health Insurance: Yes None Insurance Company: \_\_\_\_\_

#### HISTORY OF COMPLAINT - PLEASE IDENTIFY THE CONDITION(S) THAT BROUGHT YOU INTO THIS OFFICE

Primary Complaint: \_\_\_\_\_

Secondary: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of 0 to 10 with 10 being the worst pain and 0 being no pain, rate your above complaints by circling the number:

Primary complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Secondary complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Fourth complaint: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst? o AM o PM

How long does it last?  It is Constant  It is Frequent  It is Intermittent  It is Occasional  It is Infrequent

What relieves your symptoms? \_\_\_\_\_ What makes them feel worse? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past? No Yes If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

How long were you under care: \_\_\_\_\_ What were the results?  Favorable  Unfavorable \_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_  N/A

Is your problem the result of ANY type of accident?  Yes No Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### Please mark the areas on the diagram with the

If yes identify type:  Auto  Work Home  Other: \_\_\_\_\_

Have you reported this accident to anyone?  No Yes If yes to whom: \_\_\_\_\_

following letters to describe your symptoms:

R = Radiating B = Burning D = Dull S = Sharp

A = Aching N = Numbness T = Tingling

When was your most recent auto accident? \_\_\_\_\_

Identify all sports or recreational activities you participate in:

\_\_\_\_\_

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

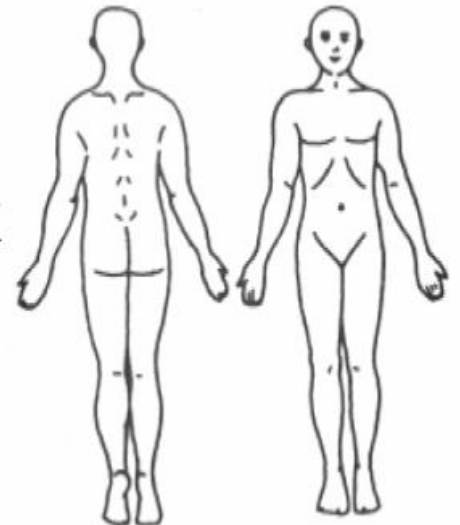
\_\_\_\_\_

Any other serious conditions the doctor should know about? \_\_\_\_\_

\_\_\_\_\_

LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL USUAL ACTIVITY LEVEL

\_\_\_\_\_ : \_\_\_\_\_



\_\_\_\_\_: \_\_\_\_\_: \_\_\_\_\_: \_\_\_\_\_:

**FAMILY HISTORY**

1. Does anyone in your family suffer with the same condition(s)?  Yes  No  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  Yes  No  I don't know
2. Any other hereditary conditions the doctor should be aware of?  No  Yes: \_\_\_\_\_

**PAST HISTORY**

1. Have you suffered with any of this or a similar problem in the past? No  Yes  If yes how many times? \_\_\_\_\_  
When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_
2. Other forms of treatment tried:  No  Yes If yes, please state what type of treatment: \_\_\_\_\_  
and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results:  Favorable  Unfavorable  
please explain: \_\_\_\_\_
3. 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:  
\_\_\_\_\_
4. If you have ever been diagnosed with any of the following conditions, please indicate with: **P = Past, C = Currently, and N = Never**  
\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer  
\_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions: \_\_\_\_\_
5. Please list any current medications you are taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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     | → _____      | _____                 | _____   |

**PLEASE MARK "P" FOR PAST, "C" FOR CURRENT, AND "N" FOR NEVER FOR EACH OF THE FOLLOWING:**

- |                        |                                  |                         |                           |                          |
|------------------------|----------------------------------|-------------------------|---------------------------|--------------------------|
| ___ Headache           | ___ Pregnant (Now)               | ___ Dizziness           | ___ Prostate Problems     | ___ Neck Pain            |
| ___ Fainting           | ___ Loss of Balance              | ___ Ulcers              | ___ Heartburn             | ___ Jaw                  |
| Pain/TMJ               |                                  |                         |                           |                          |
| ___ Frequent Colds/Flu | ___ Convulsions/Epilepsy         | ___ Digestive Problems  | ___ Heart Problems        | ___ Shoulder Pain        |
| ___ Tremors            | ___ Impotence/Sexual Dysfunction | ___ Double Vision       | ___ Colon Trouble         | ___ High Blood Pressure  |
| ___ Upper Back Pain    | ___ Chest Pain                   | ___ Blurred Vision      | ___ Diarrhea/Constipation | ___ Low Blood Pressure   |
| ___ Mid Back Pain      | ___ Pain with a Cough or Sneeze  | ___ Ringing in the Ears | ___ Menopausal Problems   | ___ Asthma               |
| ___ Low Back Pain      | ___ Foot or Knee Problems        | ___ Hearing Loss        | ___ Menstrual Problems    | ___ Difficulty Breathing |
| ___ Hip Pain           | ___ Sinus/Drainage Problem       | ___ Depression          | ___ PMS                   | ___ Lung Problems        |
| ___ Back Curvature     | ___ Swollen/Painful Joints       | ___ Irritable           | ___ Bed Wetting           | ___ Kidney Trouble       |

|   |  |                                       |  |  |
|---|--|---------------------------------------|--|--|
| <input type="checkbox"/> Scoliosis                                    | <input type="checkbox"/> Skin Problems             | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder        |
| <input type="checkbox"/> Broken Bone                                  | <input type="checkbox"/> Cerebral Vascular Problem | <input type="checkbox"/> ADD/ADHD     | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Liver               |
| Trouble   |  |                                       |  |  |
| <input type="checkbox"/> Dislocation                                  | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Trouble Sleeping    | <input type="checkbox"/> Hepatitis (A, B, C) |
| <input type="checkbox"/> Numbness/Tingling in Arms, Hands, or Fingers |  | <input type="checkbox"/> Disability   | <input type="checkbox"/> Tumor               | <input type="checkbox"/> Rheumatoid          |
| <input type="checkbox"/> Numbness/Tingling in Legs, Feet or Toes      |  | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Arthritis           |



**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

**AFFECTS OF DAILY LIVING**

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

|                            |                                    |   |   |  |
|----------------------------|------------------------------------|---|---|--|
| Bending                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Carrying                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Climbing                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Concentrating              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dancing                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Doing Chores               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Doing Computer Work        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Dressing                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Driving                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Gardening                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Lifting                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Performing Sexual Activity | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Playing Sports             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Pushing                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Reading                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Recreation                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Rolling Over               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Running                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Shoveling                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sitting to Standing        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Sleeping                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Standing                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Walking                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Watching TV                | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |
| Working                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Painful (can do) | <input type="checkbox"/> Painful (limits) | <input type="checkbox"/> Unable to Perform |

*I hereby authorize that this paperwork is filled out to the best of my knowledge.*

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

# **INFORMED CONSENT**

**REGARDING:** Exam, X-Rays, Chiropractic Adjustments, Therapeutic Procedures, and Insurance

Treatment Objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Capital City Chiropractic and Maximized Living 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 a full examination and treatment by any means, methods, and or techniques, the doctor deems necessary to determine and treat my condition at any time throughout the entire clinical course of my care.

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.

I hereby authorize payment to be made directly to Capital City Chiropractic and Maximized Living, 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 Capital City Chiropractic and Maximized Living for any and all services I receive at this office.

\_\_\_\_\_

Patient or Authorized Person's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date

Witness Initial: \_\_\_\_\_

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FEMALES ONLY: Please read carefully, and check the boxes, include the appropriate date, then sign above 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 mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant.

**----- MAXLIVING COLUMBIA 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 Personal Health Information. 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 statements below, 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. Once you have read this notice, please sign the bottom. If you would like a copy for your records one will be provided for you.

**PERMITTED DISCLOSURES:**

1. Treatment purposes: Discussion with other health care providers involved in your care.
2. Inadvertent disclosures: Open treating areas 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 imminent 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: For 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 update 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 detailed 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.

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 any 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 Name

\_\_\_\_\_  
DOB

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

----- **MAXLIVING COLUMBIA'S OFFICE POLICY** -----

**Welcome to MaxLiving!**

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 Treatment, 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 first hand 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 a 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 MaxLiving is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Clear Institute, Pettibon, Full Spine, CBP, Toggle, Gonstead, and Activator. 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 objects 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.

I hereby acknowledge receiving a copy of the practice's "Office Policies". This signature page 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.



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Patient Name

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DOB

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Patient Signature

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Date

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Witness

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Date