



New Practice Member Application

Name _____ Date of Birth ____ / ____ / ____ Age ____ Male/Female
 Address _____ City _____ State _____ Zip _____
 Phone: Cell _____ Home _____ Work _____
 Email Address _____ Occupation _____
 Employer's Name _____ Status: Single / Married / Divorced / Widowed
 Spouse's Name _____ Number of Children _____
 Names, Ages, & Gender _____
 Do you have health insurance YES NO
 Emergency contact/phone #: _____
 Relationship: _____
 Who may we thank for referring you? _____

List the Health Concerns That Brought You into This Office

↓ List Health concerns according to SEVERITY ↓	Rate the severity 0= no pain, 10= unbearable	When did this problem start?	Have you had this problem before? If yes, when?	Did the problem begin with an injury?	Are symptoms constant (C) or Intermittent (I)
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? Yes No
 If Yes: Chiropractor Medical doctor Other _____
 Who? _____ When? _____ How long? _____
 Results? _____

Day to day activity levels

<u>List any restricted activity</u>	<u>Current Activity Level</u>	<u>Usual Activity Level</u>

Scoring: Low, moderate and high



Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Jaw/TMJ Pain | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Tight/Sore Muscles |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Arthritis/Joint Pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Nausea | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numb/Tingling in Arms/Hands |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Numb/Tingling in Legs/Feet |
| <input type="checkbox"/> Hip/Leg Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Difficulty Breathing |

Other: _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- | | | | | |
|--------------------------------------|-----------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Spinal Surgery | <input type="checkbox"/> Spinal Bone Fracture |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other Conditions/Diseases |
| <input type="checkbox"/> Broken Bone | <input type="checkbox"/> Tumor | <input type="checkbox"/> Fracture | <input type="checkbox"/> Cancer | |

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

List all over the counter & prescription medications you are on, & the reason for each:

Have you ever been in an auto accident? List all: _____

Have you ever been knocked unconscious? Yes No Fractured A Bone? Yes No

If yes to either of the above, please describe: _____

Other trauma: _____

Social History

- Smoking: How often? Daily Weekends Occasionally Never
- Alcohol: How often? Daily Weekends Occasionally Never
- Exercise: How often? Daily Weekends Occasionally Never
- Have you consumed any caffeine or products with caffeine in the past 48 hours? Yes No



Activities of Life

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

<u>ACTIVITY:</u>	<u>EFFECT:</u>			
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<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
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<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
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static 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
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

What are your health goals? _____



Your Family Health History

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer's					



Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Justin Ryder, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Justin Ryder and any and all Limitless Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Limitless Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____



Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____
(If patient is minor parent/guardian signature)

Medical Information Release Form

We are unable to discuss your medical and financial information with anyone but you without written consent.

I authorize the release of information including diagnosis, records, images, examinations rendered, claims information and financial information regarding one time payments and reoccurring payment information. Please list below anyone who has the permission to any of the above information.

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

____ I choose **not** to share my information.

Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)

Volunteered Testimony and Photo Release Form

I authorize the release to Limitless Chiropractic to use my volunteered testimony and reproduce my testimony to be used in the office, social media and promotional purposes.

____ I choose **not** to share my testimony

Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)

I authorize the release to Limitless Chiropractic to use and publish my photograph and any video of me or taken with me in it to be used in the office, on social media and promotional purposes.

____ I choose **not** to share my photograph or video of me

Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)



X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Limitless Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If patient is a minor parent/guardian signature)

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Limitless Chiropractic.

Signature: _____ Date: _____

(If patient is a minor parent/guardian signature)

DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE • DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbar (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion/Extension:		
Obliques:		