3175 Osage Beach Parkway, Suite 9
Osage Beach Mo. 65065
573-348-2649
www.bestspinedoc.com

____

Patient Name (please print)

PATIENT APPLICATION FORM

Welcome to our clinic! We specialize in helping our patients achieve their highest level of health through corrective care programs. Our techniques correct the condition of the spine as well as associated musculoskeletal conditions that also affect quality of life. Our unique approach offers advances beyond other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Although we focus on corrective care programs, we realize your condition and circumstances are unique. We value and trust your decisions regarding the care you seek. We are committed and concerned about your health and would like to know your expectations regarding care.

Please check the box that best describes the type of care you are looking for at this time.

- ❏ I am only interested in a health consultation in order to find out whether rehabilitative care may help; I do not want care for my condition at this time.
- ❏ I am only interested in symptomatic care and pain relief.
- ❏ I am interested in corrective care as a long term solution to my health problems.

Please fill out the following questionnaire accurately and completely so that the doctor can thoroughly evaluate your case. The doctor will use this information you provide as well as your examination and x-rays (if required) to determine whether you are a candidate for our rehabilitative programs. Please feel free to ask questions if you need assistance. We look forward to serving you!

______________________________________ __/__/__ __/__/__

Patient Signature **DOB:** **Date:**

CONFIDENTIAL PATIENT INFORMATION

Patient Name:__________________________________ **Age:**_________ **Gender:** □M □F
Address:____**Phone:**_____________________________
City, State, Zip:______________________________ **Work Phone:**_____________________________
Email Address:____
Birth Date:____/____/_______**Marital Status:** S M D W **SSN:**_______-______-_______
Employer Name:__________________________________Occupation:__________________________
Spouse's Name:_________________________**Work/Cell:** ____________________________________
Spouse's Employer:_______________________________**Occupation:**_________________________
If Patient is Minor, Parent/Guardian's Name: **Mother:**_____________________**Father:**______________
Emergency Contact:_______________________________**Relationship**:________________________
Cell Phone:_____________________________**Work Phone:**___________________________________
Names of Children and Ages:____
How were you referred to this office?____
Primary Care Physician:__________________________________**Phone:**____________________
Do you have Health Insurance: □ Y □N **Type of Insurance:** □Commercial/Private □Medicare
□Other:____

(Please allow our staff to photocopy your <u>driver's license</u> and <u>insurance card</u>)

<u>Complete below *ONLY* if different from above and/or not included on your insurance card</u>

Patient's Relationship to Primary Insured/Party Responsible for Billing: □Self □Spouse
□Child/Dependent □Other:_________________________________

Insured Name:____
Insured DOB:____/____/______ **Age:**_______ **Gender:** □M □F **Marital Status**: S M D W
Insured Address:__________________________________ **Phone:**______________________________
City, State, Zip:__________________________________**Phone:**_________________________________
Email address:____
Employer Name:________________________________ **Occupation:**__________________________
Spouse Name:_____________________**Cell/Work Phone:**____________________________________
Spouse Employer:__________________________________ **Occupation:**_______________________
Primary Insurance:__________________________________**Policy #:**________________________
Group ID:_______

By signing below, I affirm the the above information is accurate and true:

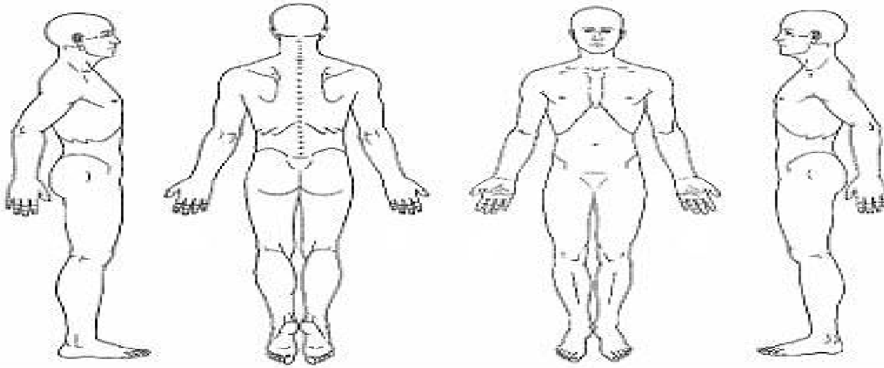
Patient Signature:____**Date:**____/_____/______

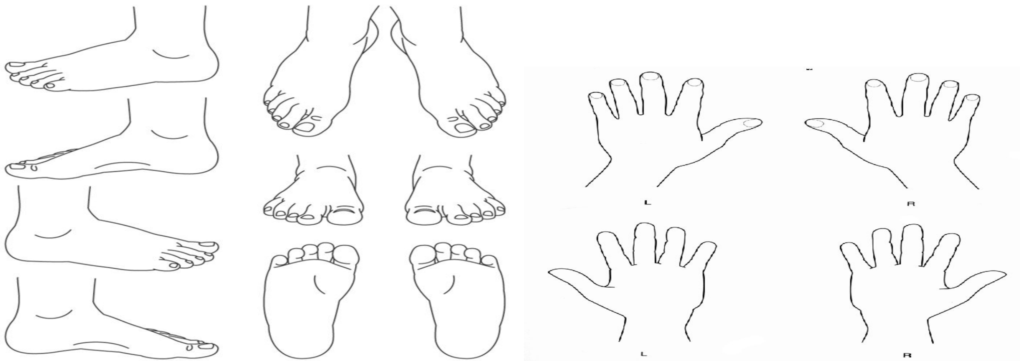
PLEASE NOTE: YOUR NAME AND DATE IS REQUIRED FOR EACH PAGE. THANK YOU

Patient Name:____**Date:**____/____/_____

Main Complaint(s):____
____
____

Circle the area(s) causing you pain on the drawings below and label each area by the type of pain





When did symptoms or conditions begin?___________________**How did it begin?**_______________
____

Is this complaint related to trauma, accident or injury? □Y □N If yes, describe;_________________
____

Have you experienced this condition before? □ Y □N If yes, describe and when;_________________
____

Has this condition become worse recently? □ Y □N If yes, how has it worsen: □Gradually □Abruptly □Erratic

If no, has it: □Remained the same □Improved Other:____

What aggravates your complaint(s):____

What relieves or improves your complaint(s):____

What have you tried to improve your complaint(s) that did not help?__________________________

Patient Name:____**Date:**____/____/_____

Describe your pain (Check all that apply**)**
□Sharp □Dull □Ache □ Burning □Throbbing □Numbness
□Tingling □Shooting □Sore □Spams
□Other:_______________________________________

Please rate the level of pain on a scale of 0 to 10, with 0 = no pain and 10 = most severe/worse pain
Circle the number below, <u>more than one area of complaint please identify each area</u>

My **Current** Pain is: 0 1 2 3 4 5 6 7 8 9 10 My **Average** Pain is**:** 0 1 2 3 4 5 6 7 8 9 10
My pain at **Best** is: 0 1 2 3 4 5 6 7 8 9 10My Pain at **Worse** is: 0 1 2 3 4 5 6 7 8 9 10
Does the pain radiate or travel? Y / N if yes, where does the pain travel or radiate?
Describe:____
____

How often does your complaint(s) affect you? □ Daily □4-6 x's/week □2-3x's week □1 week
Other:___________________________________

How often do you experience these symptoms throughout the day? □100%-Constant □75% □50% □25% □10% □Only with activity

What Activities of Daily Living are affected by your symptoms/complaint(s): (check all that apply**)**

□Almost all activities □Walking □Hobbies
□My Daily Routine □Running □Recreation/Sports Activities
□Standing □Lifting □Concentrating
□Standing for Long Periods □Bending Over □Computer Work
□Sitting □Getting Out of Bed □Daily HouseHold Chores
□Sitting for Long Periods □Daily Personal Care □Getting Dressed
□Sitting/Lying to Standing □Work Duties □Going Up/Down Stairs
□Changing Positions □Driving □Reading
□Lying Down □Sleeping □Social Activities;

Please explain or List others:____
Are symptoms Worse: □Morning □Afternoon □Evening □No change throughout day
□other:_________________________
Are your symptoms Better: □Morning □Afternoon □Evening □No change throughout the day
□Other:_____________________________________

Are you currently under medical or chiropractic care for this complaint(s)? □Y □N if yes, who have you seen for this complaint?____
What did they do?____________________________**How did you respond?**___________________
Are you currently under medical care for any other Health Condition? □Y □N if yes, explain:____

Have you had any changes in bodily functions since the condition began? □Y □N if yes, please check all that apply:

□Balance □Bowel Movement □Breathing □Vision □Weakness □Grip Strength
□Coordination □Urination □Coughing □Hearing □Fatigue □Weight Loss
□Gait □Sexual Function □Sneezing □Temperature □Weight Gain □Menstrual

Do you have any other complaints or concerns with your health?____________________________
____

DOCTORS NOTES-OFFICE USE ONLY

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____
____
____

Patient Name:____**Date:**____/____/_____

EXPERIENCE WITH CHIROPRACTOR

Have you ever received chiropractic care before? □Y □N if yes, with whom?____________________
Date of last visit___________________for how long were you receiving care?______________________
How frequent were your visits?__________________ Reason for visits:___________________________
How did you respond?_________________ Reason for ending care:______________________________
Are you aware of any of your poor posture habits? □Y □N Explain:______________________________

SOCIAL HISTORY-HEALTHY LIFESTYLE

In general would you say you health is: □Excellent □Very Good □Good □Fair □Poor □Other:_____

Compared to one year ago, how would you rate your health in general now?
□ Much better now than one year ago □About the same □Much worse than one year ago
□Somewhat better now than one year ago □Somewhat worse than one year ago

Where do you consider your health? □Highest Priority □High Priority □Average Priority
□Low Priority □None
Do you exercise? □Y □N How often per week?____
What activities? □Walking □Jogging □Weight Training □Cycling □Yoga □Pilates □Swimming
□Other:____
What is your current Height and Weight? Height_______ft________inches Weight:__________lbs
Do you smoke? □Y □N How much? □1-5cig/day □6-10 cig/day □1 pack/day □> 1 pack/day:_______
Do you drink Alcohol? □Y □N How much /week average?___________________________________
Do you drink coffee/caffeinated drinks? □Y □N How many cups/day?__________________________
Do you currently have a drug or substance abuse problem? □Y □N
Please describe your work:____
Type: □Professional □Physical Labor □Driver □Clerical □Factory □Homemaker □Other:__________
Physical Demands: □Heavy □Moderate □Mild □Sedentary Stress level: □High □Medium □Low

Do you currently take any prescription or non-prescription drugs or supplements, i.e. vitiams, minerals, herbs? List:____

Name	Reason for taking	Name	Reason for Taking

DOCTORS NOTES-OFFICE USE ONLY

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____
____
____
____
____

Patient Name:____**Date:**____/____/_____

FAMILY MEDICAL HISTORY

Note any family history:M=Mother, F=Father, S=Sibling, GP=Grandparent, Paternal Grandparent

□Cancer: □M □F □S □GP □GP

□Diabetes: □M □F □S □GP □GP

□High Blood Pressure:□M □F □S □GP □GP

□Spine or Back Disorder:□M □F □S □GP □GP

□Multiple Sclerosis:□M □F □S □GP □GP

□Psychological Disorder:□M □F □S □GP □GP

□Stroke:□M □F □S □GP □GP

□Headaches:□M □F □S □GP □GP

□Heart Disease:□M □F □S □GP □GP

□Arthritis:□M □F □S □GP □GP

Are there any other diseases or conditions that are common among your family, i.e.inherited diseases or conditions? □Y □N describe:____

REVIEW OF SYSTEMS

Please identify any area of the body that you have any condition or problem with, ast or present:

□Skin, Hair, or Nails □Digestive System □Joint(s) (ex: arthritis)

□Mouth and or Throat □Urinary(including kidney or Bladder

□Genital (e.g. prostate, testicular, vagina, uterus) □Nose and/or Sinus

□Nervous system disease □Mental health conditions □Ear(s) □Gland and/or hormone □Eye(s) □Allergy or Immunity

□Chest or lung (breathing) □Muscle, Tendon or Ligament

□Heart and/or blood vessel □Bone (ex: Osteoporosis) □Blood or lymph node

Other: ____

Females only

Do you have menstrual problems? □Y □N

Have you taken birth control or currently taking? □Y □N if yes how long:_____________________

Do you have breast problems? □Y □N

Are you or is there a possibility you are pregnant? □Y □N Please explain:____

____

PAST MEDICAL HISTORY

List any diseases the you had in the past, including childhood diseases: (ex: Chickenpox)__________

____

List any conditions you have been diagnosed with: (ex: cancer, AIDS, Cardiovascular Disease, etc.___

____

List ALL past physical injuries: (ex: falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, dislocations, broken or cracked bone, etc.____________________________

____

List all past surgeries/operations you have had:(don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy)

1.__________________Date:_____________ 5.__________________Date:_____________

2.__________________Date:_____________ 6.__________________Date:_____________

3.__________________Date:_____________ 7.__________________Date:_____________

4.__________________Date:_____________ 8.__________________Date:_____________

____

DOCTORS NOTES-OFFICE USE ONLY

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INFORMED CONSENT DOCUMENT FOR TREATMENT

PATIENT
NAME:____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The application of this procedure is either manual or a mechanical instrument the is utilized in such a way as to mobilize your joints,

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedure: Spinal Manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, radiographic studies
___Other (Please explain)____
____

The material risk inherent in chiropractic adjustment.

As with aunty healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations and burns, Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the doctor.

The Probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there are no recognized screening procedures to identify patients with neck pain who are

at risk or arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administer, over the counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risk and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREAT (MINOR)

I hereby request and authorize Dr. Wendy Ramboldt (Cobler) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_________________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (if applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW.

I have read[ ] or have had read to me[ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Wendy Ramboldt (Cobler) and have had my questions answered to my satisfaction. By signing below I state that I have weighed risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:__________________	Dated:_________________
____	____
Patient's Name	Doctor's Name
____	____
Signature	Signature

____
Signature of Parent or Guardian (if a minor)

DESIGNATION OF CERTAIN RELATIVES, FRIENDS, AND/OR OTHER CAREGIVERS

HIPAA

Patient Name:_______________________________ Date:______________________
Patient Case No.:_____________________________ Date of Birth:_______________

I agree that Cobler Chiropractic and Sports Rehab, LLC disclose certain portions of my health information to a relative, friend, and/or other caregiver because such a person is involved with my healthcare or payment relation to my health care. In that instance, Cobler Chiropractic and Sports Rehab , LLC will disclose only information that is directly relevant to the person's involvement with my healthcare payment relating to my healthcare.

□I wish to make no designation at this time.

Signature of Patient/Parent/Guardian:____

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of Cobler Chiropractic and Sports Rehab, LLC making the limited disclosures described above. <u>I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.</u>

Print Name:____________________________ DOB or Password*:_____________________________

Print Name:____________________________ DOB or Password*:_____________________________

Print Name:____________________________ DOB or Password*:_____________________________

Print Name:____________________________ DOB or Password*:_____________________________

**Please list the 4 digit (month & day) date of birth(DOB) of the person listed or choose a password.*
***Please Note**, the person will have to give his/her DOB or password in order to receive any information.*

Signature of Patient/Parent/Guardian:____