Patient Name:		Claim / Ins./ Pt ID #	
D.O.I./ D.O.B.		Date of Visit /Exam	

APPLICATION FOR TREATMENT

ALL information you supply is CONFIDENTIAL. We comply with all federal privacy standards. Please print clearly.
Please allow our staff to photocopy your driver's license and Insurance card/information.

PATIENT INFORMATION

Full Legal Name_____Age_____Birth Date____-____-_____
Preferred Name_____Gender □Male □Female Height _____ Weight _____ Blood Pressure _____ Pulse _____
Address_____City_____State_____ZIP Code _____
Home #_____Cell #_____Work #_____(Place * * by best # to reach you)
E-Mail:_____Marital Status □Married □Single □Widowed □Divorced □Separated
Your Employer_____Occupation _____
Employer/ Company Address _____
Spouse's Name_____Child's Name (& Age):_____
Who to contact in case of an emergency?_____Phone #:_____

- **How did you hear about us?** □ Doctor □ Attorney □ Existing Patient □ Google Ad □ Google Search ☐ _____

2. Reasons for seeking Chiropractic treatments:

Primary reason: _____
Secondary reason: _____
Have you ever received Chiropractic Care? □Yes □No_____
If yes, when?_____ Name of most recent Chiropractor: _____

3. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____
_____
_____

4. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □Heart problems/ high blood pressure/ chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Inflammatory Disease
□ Other _____ ☐ **None of the above**

B. Please describe any previous Injuries or Traumas (include All injuries from Sports, Slip & Fall, Work, and Auto)

_____
_____
_____
□ Broken any bones? Which? _____
□ Used neck/back brace □ Head injury – How?_____□ Knocked unconscious
□ Nerve or spine disorder □ Work/Sport/Auto Injury □ Used a crutch or support
□ Other_____□ None of the above

- **Do you have a Permanent Disability rating?** □Yes □No Percent?_____% Date rating received?_____
  Location_____As a result of :_____

C. Allergies: _____

D. Medications: Name Reason for taking

_____
_____
_____
_____

E. Surgeries: Date Type of Surgery

_____
_____
_____

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F. Females/ Pregnancies and outcomes:

Pregnancies/ Date of Delivery Outcome

_____

_____

5. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases □ Adopted/Unknown

□ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes □ Other_____ □ **None of the above**

Deaths in immediate family: _____

Cause of parents or siblings death Age at death

_____

_____

_____

6. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle and Health Habits:

Alcohol use	□ Daily	□ Weekly	How much? _____	Prayer or meditation?	□ Yes	□ No	Amount _____
Coffee/Tea	□ Daily	□ Weekly	How much? _____	Job pressure/ stress?	□ Yes	□ No	Amount _____
Tobacco use	□ Daily	□ Weekly	How much? _____	Financial Stress?	□ Yes	□ No	Amount _____
Exercising	□ Daily	□ Weekly	How much? _____	Mercury fillings?	□ Yes	□ No	Amount _____
Water Intake	□ Daily	□ Weekly	How much? _____	Recreational Drugs?	□ Yes	□ No	Amount _____
Soda Intake	□ Daily	□ Weekly	How much? _____	# of Hours of Sleep_____ & Quality of sleep? _____			

7. Review of Systems

- Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other_____ □ **None of the above**

- Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other_____ □ **None of the above**

- Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other_____ □ **None of the above**

- Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other_____ □ **None of the above**

- Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other_____ □ **None of the above**

- Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other___ □ **None of the above**

- Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other_____ □ **None of the above**

- Have you had any of the following **hematological (blood-related)** issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other_____ □ **None of the above**

- Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other_____ □ **None of the above**

- Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other_____ □ **None of the above**

*** * Is there anything else in your past medical history that you feel is important to your care here?** _____

---

8. Current Condition

Pain Scale – *Important – Please Read!*

Pain 1 - 3/10: Mild & Able to Adapt to Pain & Does not interfere w/ activity: 1/10 = Light (usually don't think about it); 2/10 = Minor Pinch; 3/10 = Tolerable pain (accidental cut)

Pain 4 - 6/10: Moderate & Unable to Adapt to Pain & *Does* interfere w/activity: 4/10 = Distressing, Strong, & Deep (stubbed toe); 5/10 = Very Distressing, Strong, Deep, & Sharp (noticeable all the time, sprained ankle, moderate back pain); 6/10 = Intense, Strong, & Deep (Dominates lifestyle, difficult at work/home, bad headache, deep back muscle spasms)

Pain 7 – 10/10: Severe & Unable to engage in normal activities, maybe unable to function independently: 7/10 = Very Intense, Pain dominates normal activities like a very intense headache; 8/10 = Utterly Horrible. Pain is extremely intense like a broken bone, dislocated joint, extreme headache; 9/10 = Unbearable, demand pain medicine like passing a kidney stone; 10/10 = pain so intense you may go unconscious and requires ER Care.

Symptom 1 _____

- On a **Pain Scale** from 0-10, with 10 being the worst, please circle the *number that best describes the symptom most of the time*: 0 1 2 3 4 5 6 7 8 9 10
- What *percentage of the time you are awake* do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When did the symptom *begin*? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom *worse*? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, Other (please describe):_____
- What makes the symptom *better*? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the *quality* of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____
- Does the symptom *radiate* to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain *times of the day or night*? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a **Pain Scale** from 0-10, with 10 being the worst, please circle the *number that best describes the symptom most of the time*: 0 1 2 3 4 5 6 7 8 9 10
- What *percentage of the time you are awake* do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When did the symptom *begin*? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom *worse*? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
    Other (please describe):_____
- What makes the symptom *better*? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    Other (please describe): _____
- Describe the *quality* of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom *radiate* to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain *times of the day or night*? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 3 _____

- On a **Pain Scale** from 0-10, with 10 being the worst, please circle the *number that best describes the symptom most of the time*: 0 1 2 3 4 5 6 7 8 9 10
- What *percentage of the time you are awake* do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When did the symptom *begin*? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom *worse*? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
    Other (please describe):_____
- What makes the symptom *better*? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    Other (please describe): _____
- Describe the *quality* of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom *radiate* to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain *times of the day or night*? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Patient Name:		Claim / Ins./ Pt ID #	
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Symptom 4 _____

- On a **Pain Scale** from 0-10, with 10 being the worst, please circle the *number that best describes the symptom most of the time*: 0 1 2 3 4 5 6 7 8 9 10
- What *percentage of the time you are awake* do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When did the symptom *begin*? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom *worse*? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing,
    Other (please describe): _____
- What makes the symptom *better*? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing,
    Other (please describe): _____
- Describe the *quality* of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom *radiate* to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain *times of the day or night*? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

ACKNOWLEDGEMENTS

☐ **I instruct the Chiropractor, and the Employees under his supervision, to deliver the care that can best help me, in their professional judgment.** I understand the care delivered to help me in the restoration of my health may include Physical Therapy, Massage Therapy, Laser Therapy, and other natural therapies. Chiropractic, Massage, and other natural therapies are a separate distinct healing art from Medicine and they do not proclaim to cure any disease.

☐ **I have received a copy of the Privacy Policy and I understand it** describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

☐ **Am I Pregnant?** If indicated, you need a x-ray exam. I realize that an X-ray examination may be hazardous to an unborn child and I certify to the best of my knowledge that I am not pregnant. Date of my last menstrual period (MM/DD/YYYY): /_____/_____

☐ **I grant permission to be called to confirm or reschedule an appointment** and to be sent by mail and email with occasional cards, letters, newsletters, health education information, or office closures notifications that is an extension of my care in this clinic.

☐ **I am responsible for the payment of care delivered to me** and of any covered or non-covered services that I receive AND acknowledge that any Insurance that I may have and any of the benefits I may have with my Insurance - is an agreement between the carrier and myself.

☐ **Dress comfortably for your treatment.** During Therapeutic Massage, draping will be used and only the area being worked will be uncovered.

☐ **We require a 24 hour notice to reschedule an appointment or you may be charged a missed appointment fee of $30.**

☐ **Clients under 17 years old must be accompanied by a parent or guardian during the treatments.**

☐ **To the best of my abilities, I have supplied complete and truthful information.** I have not misrepresented the presence, severity, or cause of my health concern.

Patient (guardian) **Signature** _____

➢ **Please review and sign the *Informed Consent* on the next page.**

Patient Name:		Claim / Ins./ Pt ID #	
D.O.I./ D.O.B.		Date of Visit /Exam	

Informed Consent

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 that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation 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 Xray. 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 is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, 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 risks 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.

Patient Name:		Claim / Ins./ Pt ID #	
D.O.I./ D.O.B.		Date of Visit /Exam	

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize (*Dr. Mark M Travers*) 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 spouse 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.

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Exam which may include: radiographic studies; range of motion testing, orthopedic & neurological testing; muscle strength testing

Treatment which may include: spinal manipulative therapy, therapeutic traction; hot/cold therapy; trigger point therapy; therapeutic stretching

PLEASE CHECK THE APPROPRIATE BLOCK 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. Mark M Travers)* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the 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.**

_____ _____

****Patient's Name** **Doctor's Name**

_____ _____

****Signature** **Signature**

_____

****Signature of Parent or Guardian (if a minor)**