DISCOVER CHIROPRACTIC LIFE CENTER

DR. JEFFREY D. ALGAJER, D.C.

"HEALTH BY CHOICE, NOT BY CHANCE"

Patient Application Form

WELCOME TO DISCOVER CHIROPRACTIC LIFE CENTER! We specialize in Neurologically-based and Postural Corrective Chiropractic Care . Our approach is very unique and advanced from other forms of care. This allows our practice members to achieve superior results.

Please fill out the following information thoroughly so the doctor can let you know if we are able to accept you as a patient. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: _____

Today's Date: _____

1107 Hazeltine Blvd., Suite 100
Chaska, MN 55318
(952) 368-4700
info@chaskachiropractor.com
chaskachiropractor.com

discover CHIROPRACTIC

Date:_____

PATIENT APPLICATION

Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names and Ages of Children: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: _____ Cell Phone: _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

YOUR HEALTH PROFILE

Please rate your overall health status:

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

What are your health objectives? _____

_____

Are you healthier today than you were 5 years ago? Yes No Not Sure

If so, what did you do to improve your health? _____

_____

If not, why do you think your health has declined? _____

_____

Have you had previous chiropractic care? Yes No If yes, what was the doctor's name: _____

What was the approximate date of your last visit? _____ What was the duration of your care? _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No

Did your previous chiropractor perform before and after neurological scans? Yes No

Do you exercise? Yes No How often? 1x 2x 3x 3x 5x per week Other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much/week? _____

Do you drink caffeinated beverages (coffee/soda/etc)? Yes No How many cups/day? _____

Do you take any supplements (vitamins, minerals, herbs, etc.)? _____

COMPLETE ALL QUESTIONS BELOW

1. What are your **major complaint(s)/illnesses?**_____
_____

2. What are your **minor complaint(s)/illnesses?**_____
_____

3. How **long** have you been experiencing your major complaint? □ Days □ Weeks □ Months □ Years

4. What caused or brought on your complaint?
_____
_____

5. When did this condition begin? _____ Has it gotten: Better Worse Stayed the Same

6. What have you done **prior** to coming to this office to treat your major and minor complaints? _____
_____
_____

7. When do you **notice** your complaint or complaints the most? □ AM □ PM □ BOTH

8. How long does it last? _____Minutes _____Hours

9. What makes it feel **worse**? □ Sitting □ Standing □ Lying □ Activity □ Other_____

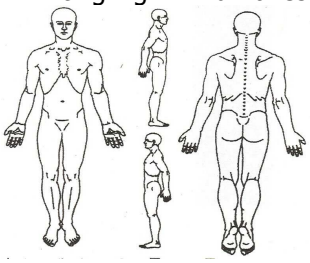
10. What makes it feel **better**? □ Sitting □ Standing □ Lying □ Activity □ Drugs □ Other_____

11. What best describes the character and quality of your major illness or pain?

A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain

12. Have you ever had this problem in the past? □ Yes □ No

13. On the diagram below, please **show** where you are experiencing all of your present complaints using the following letters: A: ache B: burning pain T: tingling N: numbness S: sharp K: cramping D: dull pain



14. On the scale below, please **circle** the **severity and intensity** of your **main complaint** (at its' worst):

None		**Slight**		**Mild**			**Moderate**		**Severe**
1	2	3	4	5	6	7	8	9	10

15. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

Occasional			**Intermittent**			**Frequent**			**Constant**
10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

16. Does your pain radiate? _____Y _____N Where does it radiate to? _____

Signature _____ **Date** _____

HEALTH CONDITIONS

All health problems are the result of abnormal cells, disturbing normal function in your body. For instance, abnormal cells located in your eye may be diagnosed as Glaucoma or Conjunctivitis, in your brain it may be diagnosed as Alzheimer's or Parkinson's, in your knee, Osteoarthitis or Tendonitis, etc. When the vertebrae in your spine are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called Subluxations. It has been extensively documented that subluxation, causing disturbance to your nerves, will weaken and distort the overall structure of your spine, damage your nervous system and create abnormal cells in the respective tissues. Postural distortions and subluxations have many serious and adverse effects on your overall health. Please check any health condition you are experiencing now or have in the past.

CERVICAL SPINE (NECK):

Neurologic disturbances from subluxation in your neck will damage the nerves leading to your arms, hands and head affecting these parts of your body. Do you experience...?

- ☐ Neck Pain
- ☐ Pain into your Shoulders/Arms/Hands
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Hearing Disturbances
- ☐ Weakness in Grip Strength
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Coldness In Hands
- ☐ Thyroid Conditions
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurring Colds/Flu
- ☐ Low Energy/Fatigue
- ☐ Depression/Anxiety

THORACIC SPINE (UPPER BACK)

Neurologic disturbances from subluxation in your upper back will damage nerves leading to your heart, lungs and shoulders, affecting these parts of your body. Do you experience...?

- ☐ Heart Palpitations
- ☐ Heart Murmurs
- ☐ Tachycardia
- ☐ Heart Attacks
- ☐ Angina
- ☐ Recurring Lung Infections/Bronchitis
- ☐ Asthma/Wheezing
- ☐ Shortness of Breath
- ☐ Pain on Deep Inspiration/Expiration

THORACIC SPINE (LOWER BACK)

Neurologic disturbances from subluxation in your mid back will damage nerves leading to your ribs/chest, stomach and upper digestive tract, affecting these parts of your body. Do you experience...?

- ☐ Mid Back Pain
- ☐ Pain Into Chest/Ribs
- ☐ Indigestion/Heartburn
- ☐ Nausea
- ☐ Bloating
- ☐ Ulcers/Gastritis
- ☐ Hypoglycemia/Hyperglycemia
- ☐ Tired/Irritable After Eating
- ☐ Tired/Irritable When You Haven't Eaten For A While
- ☐ Irritable Bowel
- ☐ Immune Deficiencies/AutoImmune Problems

LUMBAR SPINE (LOW BACK)

Neurologic disturbances from subluxation in your lower back will damage nerves leading to your legs/feet, lower digestive organs and reproductive organs, affecting these parts of your body. Do you experience...?

- ☐ Pain Into Hips/Legs/Feet
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Coldness in Legs/Feet
- ☐ Muscle Cramps in Legs/Feet
- ☐ Constipation
- ☐ Diarrhea
- ☐ Recurrent Bladder Infections
- ☐ Frequent/Difficulty Urination
- ☐ Menstrual Irregularities/Cramping (Females)
- ☐ Prostate Problems (Males)
- ☐ Sexual Dysfunction
- ☐ Fertility Problems
- ☐ Low Back Pain

Please list any health conditions not mentioned: _____

Please list any and all medications taken and their purpose: _____

Please list all past surgeries: _____

Please list any past traumatic injuries, like car accidents: _____

DISCOVER CHIROPRACTIC LIFE CENTER

DR. JEFFREY D. ALGAJER, D.C. — DR. MATHIAS G. PAMER, D.C.

"HEALTH BY CHOICE, NOT BY CHANCE"

There is a proverb which happens to be our motivation at Discover Chiropractic and the reason we do, what we do:

"When you have your health you have 1,000 dreams, and when you don't, you have one."

This is the most profound concept because it is so true.

Health is our greatest asset because we can never reach our goals in life without it! Our purpose is to help you restore your health to ensure your goals and dreams have the opportunity to become reality. We'd like to know what that looks like for you?

What are your life goals and where do you see yourself in the next 5 to 10 years?

1._____

2._____

3._____

4._____

5._____

_____ _____

Signature **Date**

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures.

NOTE: It is understood and agreed the amount paid to Discover Chiropractic Life Center for x-ray, is for examination only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

CONSENT TO CARE

I do hereby authorize the doctors of Discover Chiropractic Life Center to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays or any other procedure that is advisable, and necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures related to my health care. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre- existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic.

I also clearly understand that if I do not follow the Doctors specific recommendations at this clinic that I will not receive the full benefit from the programs offered, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor for all services rendered. I also understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I shall be personally liable for any and all of the unpaid balance to the doctor.

I, _____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature_____ Date _____ *(If under age 18) Parent's signature*

INSURANCE AND FINANCIAL POLICIES

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to Discover Chiropractic.

I understand that Discover Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Discover Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Discover Chiropractic will be credited to my account upon receipt. **However**, I clearly understand and agree that all my services rendered to me are charged directly to me and that I am responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. If an account balance remains unpaid for three months or longer, a monthly interest fee of 2% will apply to account balance. I authorize Discover Chiropractic to obtain a credit report if deemed necessary.

Signature_____ Date _____ *(If under age 18) Parent's signature*

In case of emergency, please notify: _____

Relationship: _____

Address: _____

_____

_____

Phone #: _____

FOR OFFICE USE ONLY:

Patient Status At Time Of Consent:

- ☐ Of Legal Age
- ☐ Oriented x3
- ☐ Coherent/Lucid
- ☐ Proficient English
- ☐ Assisted by Interpreter
- ☐ Medicated, but Unimpaired
- ☐ Denies Use of Alcohol or Recreational Drugs Prior to Consent
- ☐ Unable to Give Legal Consent
- ☐ Consent Given Via Legal Guardian

I certify that this form accurately reflects the patient's status during the informed consent process.

_____ _____

Doctor/Staff Signature Date