



Date: \_\_\_\_\_

## PATIENT APPLICATION SURVEY

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: S M D W  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: \_\_\_\_\_  
Is this purpose related to an auto accident / work injury? • Yes • No If so, when: \_\_\_\_\_  
When did this condition begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ Did it begin: Gradual Sudden Progressive over time  
What activities aggravate your symptoms? \_\_\_\_\_  
Is there anything, which has relieved your symptoms? • Yes • No Describe: \_\_\_\_\_  
Type of Pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting  
Does the Pain Radiate into your: \_\_Arm \_\_Leg \_\_Does not radiate Is this condition getting worse? • Yes • No  
How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity  
Does complaint(s) interfere with: \_\_Work \_\_Sleep \_\_Hobbies \_\_Daily Routine Explain: \_\_\_\_\_  
Have you experienced this condition before? • Yes • No If so, please explain: \_\_\_\_\_  
Who have you seen for this? \_\_\_\_\_ What did they do? \_\_\_\_\_  
How did you respond? \_\_\_\_\_

## EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? • Yes • No Who? \_\_\_\_\_ When? \_\_\_\_\_  
Reason for visits: \_\_\_\_\_  
Did you know posture determines your health? • Yes • No  
Are you aware of any of your poor posture habits? • Yes • No  
Explain: \_\_\_\_\_

Are you aware of any poor posture habits in your spouse or children? • Yes • No

Explain: \_\_\_\_\_

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health.

**Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck?** Yes No

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae 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 (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse effects on your overall health. The most common and detrimental postural distortion is called Forward Head Syndrome (a “hunched forward” posture starting in the neck and progressively moving down your spine weakening the entire body).

## HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 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 coffee? Yes No How many cups / day? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications currently taking and their purpose : \_\_\_\_\_

Please list all past surgeries: \_\_\_\_\_

Please list all previous accidents and falls:

\_\_\_\_\_

## INSURANCE

**Name of Primary Carrier:** \_\_\_\_\_ **Insured DOB:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Insurance ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Name of Secondary Carrier:** \_\_\_\_\_ **Insured DOB:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Insurance ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_

# SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction
ATLAS		
AXIS		
CERVICAL SPINE		
1st		
THORACIC		
3C	Cheeks, outer ear, face bones, teeth, tri-facial nerve.	<input type="checkbox"/> neuralgia, <input type="checkbox"/> neuritis, <input type="checkbox"/> acne or pimples, <input type="checkbox"/> eczema.
4C	Nose, lips, mouth, eustachian tube.	<input type="checkbox"/> hay fever, <input type="checkbox"/> runny nose, <input type="checkbox"/> hearing loss, <input type="checkbox"/> adenoids.
5C	Vocal cords, neck glands, pharynx.	<input type="checkbox"/> laryngitis, <input type="checkbox"/> hoarseness, <input type="checkbox"/> throat conditions such as sore throat or quinsy.
6C	Neck muscles, shoulders, tonsils.	<input type="checkbox"/> stiff neck, <input type="checkbox"/> pain in upper arm, <input type="checkbox"/> tonsillitis, <input type="checkbox"/> chronic cough, <input type="checkbox"/> croup.
7C	Thyroid gland, bursae in the shoulders, elbows.	<input type="checkbox"/> bursitis, <input type="checkbox"/> colds, <input type="checkbox"/> thyroid conditions.
THORACIC SPINE		
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	<input type="checkbox"/> asthma, <input type="checkbox"/> cough, <input type="checkbox"/> difficult breathing or shortness of breath, <input type="checkbox"/> pain in lower arms and hands.
2T	Heart, including its valves and covering; coronary arteries.	<input type="checkbox"/> functional heart conditions and certain chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.	<input type="checkbox"/> bronchitis, <input type="checkbox"/> pleurisy, <input type="checkbox"/> pneumonia, <input type="checkbox"/> congestion, <input type="checkbox"/> influenza.
4T	Gall bladder, common duct.	<input type="checkbox"/> gall bladder conditions, <input type="checkbox"/> jaundice, <input type="checkbox"/> shingles.
5T	Liver, solar plexus, circulation (general).	<input type="checkbox"/> liver conditions, <input type="checkbox"/> fevers, <input type="checkbox"/> blood pressure problems, <input type="checkbox"/> poor circulation, <input type="checkbox"/> arthritis.
6T	Stomach.	<input type="checkbox"/> stomach troubles or nervous stomach, <input type="checkbox"/> indigestion, <input type="checkbox"/> heartburn, <input type="checkbox"/> dyspepsia.
7T	Pancreas, duodenum.	<input type="checkbox"/> ulcers, <input type="checkbox"/> gastritis.
8T	Spleen.	<input type="checkbox"/> lowered resistance.
9T	Adrenal and supra-renal glands.	<input type="checkbox"/> allergies, <input type="checkbox"/> hives.
10T	Kidneys.	<input type="checkbox"/> kidney troubles, <input type="checkbox"/> hardening of the arteries, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> nephritis, <input type="checkbox"/> pyelitis.
11T	Kidneys, ureters.	<input type="checkbox"/> skin conditions such as acne, <input type="checkbox"/> pimples, <input type="checkbox"/> eczema, <input type="checkbox"/> or boils.
12T	Small intestines, lymph circulation.	<input type="checkbox"/> rheumatism, <input type="checkbox"/> gas pains, <input type="checkbox"/> certain types of sterility.
LUMBAR		
1st		
LUMBAR SPINE		
1L	Large intestines, inguinal rings.	<input type="checkbox"/> constipation, <input type="checkbox"/> colitis, <input type="checkbox"/> dysentery, <input type="checkbox"/> diarrhea, <input type="checkbox"/> some ruptures or hernias.
2L	Appendix, abdomen, upper leg.	<input type="checkbox"/> cramps, <input type="checkbox"/> difficult breathing, <input type="checkbox"/> minor varicose veins.
3L	Sex organs, uterus, bladder, knees.	<input type="checkbox"/> bladder troubles, <input type="checkbox"/> menstrual troubles such as painful or irregular periods, <input type="checkbox"/> miscarriages, <input type="checkbox"/> bed wetting, <input type="checkbox"/> impotency, <input type="checkbox"/> change of life symptoms, <input type="checkbox"/> many knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.	<input type="checkbox"/> sciatica, <input type="checkbox"/> lumbago, <input type="checkbox"/> difficult, painful, or too frequent urination, <input type="checkbox"/> backaches.
5L	Lower legs, ankles, feet.	<input type="checkbox"/> poor circulation in the legs, <input type="checkbox"/> swollen ankles, weak ankles and arches, <input type="checkbox"/> cold feet, <input type="checkbox"/> weakness in the legs, <input type="checkbox"/> leg cramps.
SACRUM	Hip bones, buttocks.	<input type="checkbox"/> sacro-iliac conditions, <input type="checkbox"/> spinal curvatures.
COCCYX	Rectum, anus.	<input type="checkbox"/> hemorrhoids (piles), <input type="checkbox"/> pruritis (itching), <input type="checkbox"/> pain at end of spine on sitting.

\*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

# TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and is accepted for such care, it is essential for both parties to be working towards the same objective. 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. NOTE: It is understood and agreed the amount paid to Revelation Chiropractic 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 Revelation Chiropractic 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 Revelation Chiropractic 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 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 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_ being the parent of legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Consent to X-ray

I hereby grant Revelation Chiropractic, LLC permission to perform an x-ray evaluation if needed. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition. This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation.

Date of last menstrual cycle (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date