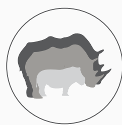


RYNO Family Chiropractic

Patient Application

About You

Name: ______________________________

Date of Birth: __________ Age: ________ Gender: ______

Address: ______________________________

City: ______________ State: ________ Zip code: ______

Home Phone: __________ Cell Phone: ______________

Email Address: ______________________________

Marital Status: ______________________________

Number of Children: ______________________________

Occupation: __________ Position Title: ______________

Employer Address: ______________________________

Work Phone: ______________________________

About Your Family

Spouse Name: ______________________________

Spouse Employer: ______________________________

Position/Title: ______________________________

Kid's Names & Ages:

____

____

____

____

Chiropractic Experience

Are you aware that...

Doctors of Chiropractic work with the nervous system?

☐ Yes ☐ No

The nervous system controls all bodily functions and systems?

☐ Yes ☐ No

Chiropractic is the largest natural healing profession in the world?

☐ Yes ☐ No

Who can we thank for referring you?

____

Have you seen or heard of our office because of...
(Check all that apply)

☐ Website
☐ Google (+)
☐ Word of mouth
☐ Yelp
☐ Community event/talk
☐ Other ______________

Reason for Seeking Care

Describe the reason for this visit:

____

When did this health concern begin?

____

How did this health concern begin?

____

What makes it better?

____

What makes it worse?

____

Any time of the day where is bothers you most?

____

Does the health concern radiate anywhere else on the body? ☐ Yes ☐ No ______________

Has the health concern:

☐ Gotten worse
☐ Stayed Constant
☐ Gotten Better
☐ Come and gone

This health concern interferes with (mark all that apply):

☐ Work
☐ Sleep
☐ Walking
☐ Sitting
☐ Exercise/Sports
☐ Recreation
☐ School
☐ Love Life
☐ Eating
☐ Other (explain below)

____

Has this health concern occurred before? If yes, explain below ☐ Yes ☐ No

____

Have you seen other doctors for this health concern?

☐ Yes ☐ No

Doctor's name:

____

Type of treatment:

____

Results: ☐ Good ☐ Bad ☐ Indifferent

Have you been adjusted by a chiropractor before?

☐ Yes ☐ No

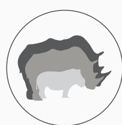
If yes, what was the reason for those visits?

____

Doctor's Name ______________ ***Approx. Date of last visit*** ______________

Has any family member ever seen a chiropractor?

☐ Yes ☐ No



RYNO Family Chiropractic

Patient Application Pg. 2

Health History

Mark appropriate squares (X) past or (√) present condition

- ☐ Allergies
- ☐ Asthma
- ☐ Constipation/Diarrhea
- ☐ Diabetes
- ☐ Dizziness
- ☐ Fatigue
- ☐ Heart condition
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sinus troubles
- ☐ Stroke
- ☐ Anxiety
- ☐ Cancer
- ☐ Depression
- ☐ Difficult breathing
- ☐ Ear ache
- ☐ Headaches
- ☐ High blood pressure
- ☐ Mental conditions
- ☐ Scoliosis
- ☐ Sleep difficulties
- ☐ Sore throat
- ☐ Thyroid condition

Name any vitamins, supplementation, and medication (prescription drugs & OTC):

____

____

____

WOMEN ONLY:

Are you pregnant?

☐ Yes ☐ No

If yes: Name of Doula, Midwife, or OBGYN:

____

Where will you be birthing your baby?

☐ Home ☐ Birthing Center ☐ Hospital ☐ Other:

____

Difficulty Nursing? ☐ Yes ☐ No

Taking birth control? ☐ Yes ☐ No

Painful periods? ☐ Yes ☐ No

Irregular cycles? ☐ Yes ☐ No

Health & Wellness Through Chiropractic Care

The human body is inherently designed to be healthy. The primary system in the body which coordinates health is the NERVOUS SYSTEM. The vertebrae, (bones of the spine) surround and protect the delicate NERVOUS SYSTEM. Misalignment to the spinal column may lead to altered function of the nervous system, known as Vertebral Subluxation.

The Chiropractic Exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process. Please review and indicate your history of "stresses" (below) so that we can assess their relationship to your present health status and examination findings. We will discuss this during the consultation, exam, and report of findings.

History of Physical Stresses *(Birth to Present)*

The birth process can traumatize a baby's spine and cause damage to the nerve system.

Please indicate to the best of your recollection where you were birthed (check all that apply):

☐ Home ☐ Birthing Center ☐ Hospital

How were you birthed?

- ☐ Natural/Non Medical
- ☐ Forceps/Suction
- ☐ Cord around neck
- ☐ Drug induced labor
- ☐ Caesarian Section
- ☐ Vaginal
- ☐ Prolonged labor
- ☐ Breech

The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status.

Have you had any accidents related to any of the following? (Check all that apply)

- ☐ Automobile
- ☐ Bicycle
- ☐ Playground
- ☐ Motorcycle
- ☐ Sports
- ☐ Abuse

If yes, please explain how and dates:

____

____

Have you ever injured your spine (head,neck, ribs/chest area, back, pelvis or hips)?

☐ Yes ☐ No

If yes, please explain how and dates:

____

____

Have you ever had any surgeries, broken any bones, or sprained any part of your body?

☐ Yes ☐ No

If yes, please explain how and dates:

____

____

Have you ever been hospitalized?

☐ Yes ☐ No

If yes, please explain how and dates:

____

____

RYNO Family Chiropractic

Patient Application Pg. 3

History of Chemical Stresses

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Were you vaccinated? ☐ Yes ☐ No

If yes, did you have a reaction? ☐ Yes ☐ No

If yes, please explain:

____

Have you ever been exposed to any of the following on a regular basis (past or present)?

☐ Toxic chemicals ☐ Drugs (Prescribed or not)
☐ Second hand smoke ☐ Other

If yes, please explain:

____

Do you have allergies to any food?

☐ Yes ☐ No

If yes, please describe:

____

Do you consume any of the following presently?

☐ Coffee/caffeine ☐ Alcohol
☐ Tobacco ☐ Over the Counter drugs
☐ Prescribed drugs

Please list all medications (prescribed or over the counter) and side-effects you are experiencing:

____

____

History of Emotional Stresses

It is difficult to separate the emotional stress in our life from the physical response that often occurs.

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma? ☐ Yes ☐ No

Loss of a loved one? ☐ Yes ☐ No

Abuse? ☐ Yes ☐ No

Work or school? ☐ Yes ☐ No

Divorce/separation? ☐ Yes ☐ No

Lifestyle change? ☐ Yes ☐ No

Financial? ☐ Yes ☐ No

Parents' divorce? ☐ Yes ☐ No

Illness? ☐ Yes ☐ No

If yes, please explain:

____

Quality of Life

How do you grade your physical health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you grade your emotional/mental health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

How do you rate your overall "quality of life?"
☐ Excellent ☐ Good ☐ Fair ☐ Poor

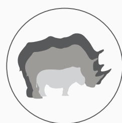
Getting to Know You

Here at Ryno Family Chiropractic we recognize that everyone enters the office with certain health challenges. With that being said our goal is not to get rid of any condition that you have been diagnosed with. The unique mission of Ryno Family Chiropractic is to enhance your life through Chiropractic Adjustments, Education, and Empowerment so you are able to experience and expression life to its fullest.

In order for me to understand your needs and create a more complete direction for your health, please share what your Top 3 Health Enhancing Goals.
1.
2.
3.

What is your commitment level to your health using chiropractic care as the foundation for your success?

☐ LOW ☐ MEDIUM ☐ HIGH



RYNO Family Chiropractic

Terms of Acceptance

When a person seeks Chiropractic care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic 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 a specific application of forces to facilitate the body's correction of the vertebral subluxation. Our Chiropractic method of correction is by specific adjustments to the spine. The doctor will walk through this process with you step by step.

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

Vertebra Subluxation- A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nervous system function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

The Goal of Chiropractic Care- The goal of Chiropractic care is to detect, analyze, and adjust vertebral subluxations to allow the body's innate ability to express its maximum health potential.

Diagnosis- We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinals examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Consent to Care

I do hereby authorize the Doctors of Ryno Family Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, Chiropractic spinal adjustments and other Chiropractic procedures, including 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.

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. 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.

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_______________________________

Consent to Care (continued)

Pregnancy Release:

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. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle: ___________________

Signature_______________________________________ Date ______________

Consent to x-ray:

I hereby grant Ryno Family Chiropractic, permission to perform an x-ray evaluation if needed of. I understand that x-rays are being performed to locate vertebral subluxation, and not to diagnose or treat any other disease or condition.

Signature_______________________________________ Date ______________

Consent to evaluate and adjust a minor child:

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 use picture and/or first name in office or social media:

I, _______________________give consent for my picture and/or first name to be used in office (example but not limited to: Patient of the Month) or on social media for Ryno Family Chiropractic

Signature_______________________________________ Date ______________

Insurance Information:

I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. The Doctors office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.

Signature_______________________________________ Date ______________

Doctor Information:

Print_______________________

Signature_______________________________________ Date ______________