New Practice Member Application

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Phone: Cell_____Home_____Work _____

Email Address_____ Occupation_____

Employer's Name_____ Status: Single /Married/Divorced/Widowed

Spouse's Name_____ Number of Children_____

Names, Ages, & Gender_____

Who may we thank for referring you or how did you hear about Level Up Health Chiropractic ?

_____

Reasons That Brought You into This Office

List Health concerns according to SEVERITY	Rate the severity 0= no pain, 10= unbearable	When did this problem start?	Have you had this problem before? If yes, when?	Did the problem begin with an injury?	Are symptoms constant (C) or Intermittent (I)
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ How long? _____

Results?_____

Day to day activity levels

List any restricted activity	Current Activity Level	Usual Activity Level

Chiropractic and Lifestyle goals

How often do you exercise? ☐ Never ☐ In the Past ☐ Occasionally ☐ Daily

Work environment ergonomics: ☐ Standing ☐ Sitting ☐ In the car

How much water do you drink?_____

What are the health and lifestyle goals you hope to achieve while under chiropractic care?

PLEASE CHECK ALL THAT APPLY:

☐ Decrease the *severity and intensity* of my symptom/problem

☐ Decrease *frequency* of my symptom/problem

☐ Improve my ability to adapt to stress

☐ By the end of my corrective care, I hope I am better able to... _____

☐ List three health goals :

1. _____
2. _____
3. _____

Scoring: Low, moderate and high

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Sexual Dysfunction
___ Migraines	___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Menstrual Problems	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Prostate Problems	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Arthritis/Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ High/Low Blood Pressure
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other:_____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___Stroke ___Cancer ___Heart Attack ___Spinal Surgery ___Spinal Bone Fracture

___Scoliosis ___Diabetes ___Arthritis ___Seizures ___Other Conditions/Diseases

___ Broken Bone ____ Tumor ___ Fracture ____ Cancer

List all surgical operations & years: _____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

List all over the counter & prescription medications you are on, & the reason for each:

_____

Have you ever been in an auto accident? List all:_____

Have you ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

Other trauma:_____

Chemical & Environmental Exposure (please rate your CONSUMPTION for each: 1 = None, 5 = High)

Smoking 1 2 3 4 5 Dairy 1 2 3 4 5 Gluten 1 2 3 4 5

Processed Foods 1 2 3 4 5 Alcohol 1 2 3 4 5 Sugar 1 2 3 4 5

Caffeine 1 2 3 4 5 Air pollution 1 2 3 4 5

Stresses & Challenges (please rate your STRESS for each: 1 = None, 5 = High)

Home 1 2 3 4 5 Work 1 2 3 4 5 Money 1 2 3 4 5

Health 1 2 3 4 5 Family 1 2 3 4 5 Life 1 2 3 4 5

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____
(If patient is a minor parent/guardian signature)

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Carrying Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	✈ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climbing Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Household Chores	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lifting Children	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dressing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Concentration (Reading)	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Your Family Health History

This form is to assist the doctors by providing past health history information for their review.

CONDITION	SPOUSE	MOTHER	FATHER	GRANDMOTHER	GRANDFATHER
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Arthritis/Joint Pain					
Ear Infections					
Hearing Loss					
Dizziness					
Loss Of Energy					
Nervousness					
Blurred/Double Vision					
Anxiety					
ADD/ADHD					
Depression					
Allergies					
Sinus Issues					
Thyroid Problems					
Asthma					
Breathing Problems					
Heart Problems					
High/Low Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Sciatica					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart Disease					
Diabetes					
Arthritis					
Alzheimer’s					

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant finding will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Ian Eshbaugh, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: _____

Signature: _____ Date: _____

If This Health Profile Is For A Minor/Child, Please Fill Out And Sign Below
Written Consent For A Child

Name of practice member who is a minor/child: _____

I authorize Dr. Ian Eshbaugh and any and all Level Up Health Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Level Up Health Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____
(If patient is minor parent/guardian signature)

Medical Information Release Form

We are unable to discuss your medical and financial information with anyone but you without written consent.

I authorize the release of information including diagnosis, records, images, examinations rendered, claims information and financial information regarding one time payments and reoccurring payment information. Please list below anyone who has the permission to any of the above information.

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
____ I choose **not** to share my information.
Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)

Volunteered Testimony and Photo Release Form

I authorize the release to Level Up Health Chiropractic to use my volunteered testimony and reproduce my testimony to be used in the office, social media and promotional purposes.

____ I choose **not** to share my testimony
Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)

I authorize the release to Level Up Health Chiropractic to use and publish my photograph and any video of me or taken with me in it to be used in the office, on social media and promotional purposes.

____ I choose **not** to share my photograph or video of me
Signature: _____ Date: _____
(If patient is a minor parent/guardian signature)

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Level Up Health Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(If patient is a minor parent/guardian signature)

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Level Up Health Chiropractic.

Signature: _____ Date: _____

(If patient is a minor parent/guardian signature)

DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE

Cervicals (cm)	Thoracics (cm)	Lumbars (cm)
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion/Extension:		
Obliques:		

Level Up Health Chiropractic Auto Injury Questionnaire

Name_____ Cell #_____

Your Auto Ins Co._____ Home #_____

Name on Policy (if other than yourself) _____

Attorney Information

Name _____ Phone # ( ) _____ Ext: _____

Address _____ City _____ State _____ Zip Code_____

Details of Accident

1. Date of Accident _____ Time of Day_____
2. Were you the: DRIVER / PASSENGER / BACK SEAT DRIVER SIDE / BACK SEAT PASSENGER SIDE
3. Does your car have a head rest? Yes or No If yes, what setting was it at time of accident?
   Bottom of Neck / Bottom of Head / Middle of Head
4. Number of People In Vehicle: _____ Were you wearing seat belts? Yes / No
5. Were you struck from: Behind / Front / Driver side / Passenger Side
6. Speed of your car? _____MPH Other Car? _____ MPH
7. Were you knocked unconscious? Yes / No If yes, how long? _____
8. Were the Police Notified? Yes / No
9. Kind of car you were driving: Model_____ Make_____ Year _____
10. How much damage to your car? $_____ or / Totaled
11. In your own words, please describe the accident:
    _____
    _____
12. Did you have any physical complaints BEFORE THE ACCIDENT? Yes / No
    If yes, please describe: _____
13. Please describe how you felt: During the accident _____
    Immediately after the accident: _____
    Later that Day: _____ The next Day: _____
14. Where were you taken after the accident? _____
    What type of treatment did you receive? _____
15. What other Doctors have treated you since the accident if any? _____
16. Since the accident, your symptoms are: Improving / Getting Worse / Same
17. Have you lost time from work as a result of this accident? Yes / No
18. Have you noticed any activity restrictions as a result of this accident? Yes / No
    If yes explain: _____

P.I. PATIENT PROVIDER CONTRACT AND PROMISSORY NOTE

Entered This Day Between Dr. Ian Eshbaugh (Hereinafter "Provider") and

_____ (Hereinafter "patient"). Provider hereby agrees to establish active account for the patient and to provide essential services for the purpose if benefiting and improving Patients current health condition. Patient hereby agrees to pat Provider in full for services performed by provider. Patient and Provider acknowledge that patient retains any and all rights of suit to procure payment for and benefit patient may be entitled.

In consideration of and for Provider rendering essential chiropractic and medical services to patient, and for the temporary suspension of any collection activity by provider by the maintenance of an active account while not receiving payment at the point of service. Patient hereby authorizes and directs the following actions be taken on patients behalf.

I. PATIENT AUTHORIZATIONS TO LIABILITY INSURANCE CARRIER: in consideration of the services to be rendered to patient by the provider that patient and provider are privy of contact and in lien of provider sending direct billing liability insurance carrier patient authorizes and directs liability insurance company to disclose the settlement status of patients claim to provider upon request, including settlement amounts thereof. After such time that patient has settles the claim with the liability carrier, in consideration that provider has not demanded payment at the point of service, Patient directs the liability carrier to include the name of provider on any check to patient upon such settlement. In the event payment is made to patient attorney after settlement of the claim. Patient further authorizes and directs the liability company to issue check to provider for the full amount owed for chiropractic and or medical services rendered to fully satisfy patients obligation to provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If patient hires an attorney; Patient

acknowledges that patient is represented by _____ Attorney of Law. Patient and provider stipulates that representation by the above-named attorney prior to settlement, judgement or verdict in the patients claim. Provider shall have the options to terminate this agreement and immediately collect from patient the full amount then owed to provider. Patient directs attorney to disclose to provider upon request the settlement status and amount of patient claim to include amount of all outstanding medical bills, dollar amount of any offer and counter offers as well as date and reason of termination or dismissal, patient last address, telephone number and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay provider for services rendered after any settlement, judgment or verdict rendered in patients claim. Patient acknowledges and agrees to remain personally liable to provider for any unpaid account balance to provider. This agreement survives this attorney client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: in the event liability, insurance carrier or patients attorney do not honor agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing, with patients attorney the likely representative for patient.

IV. PROMISORY NOTE: For the consideration stated above; patient promises to pay provider the full balance in patients account for services rendered to patient. Payment shall be due and payable within 30 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by patient and treated by provider whichever event occurs first, provided agreement has not been terminated by parties prior to these events, in which case the account balance will be due in full 3 (three) days after termination. Further patient agrees to the following:

IN THE EVENT PATIENTS ACCOUNT IS NOT PAIN IN FULL WITHIN 30 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORYNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENT ACCOUNT SHALL BECOME DELINQUENT. IF PATIENT ACCOUNT BECOMES DELINQUENT, PATIENT AGREES TO PAY COLLECTION AGENCY FEES AT 16% OF PATIENT ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE. PATIENT FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFORTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event patient terminates this agreement. Patient shall pay full balance of patients account within 3 (three) days of termination or the account shall be in default. Patient and provider fully acknowledge that this document contains full, final and entire agreement between the patients. There are no other terms to this agreement. Patient has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provisions shall remain in full force.

Date of Agreement _____ _____

Patient Signature or Guardian If A Minor