

Whom may we thank for referring you to this office? \_\_\_\_\_

## APPLICATION FOR CARE AT STRONGHOLD HEALTH

Today's Date: \_\_\_\_\_

HRN: \_\_\_\_\_

### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_ o Male o Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

Marital Status:  Single  Married Do you have Insurance:  Yes  No Work #: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Number of children and Ages: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

### HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_  
Secondarily: \_\_\_\_\_ Third: \_\_\_\_\_ Fourth: \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by **circling the number**:

Primary or chief complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaints is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? \_\_\_\_\_ When is the problem at its worst? o AM o PM o mid-day o late PM

How long does it last?  It is constant OR  I experience it on and off during the day OR  It comes and goes throughout the week

How did the injury happen? \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  No  Yes If yes, when: \_\_\_\_\_ by whom? \_\_\_\_\_

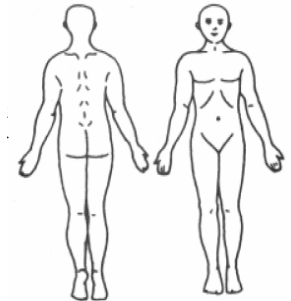
Name of Previous Chiropractor: \_\_\_\_\_ How long were you under care: \_\_\_\_\_ What were the results?: \_\_\_\_\_  N/A

\*PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling

What relieves your symptoms? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_



LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY
LEVEL		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is your problem the result of ANY type of accident? o Yes, o No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

**PAST HISTORY**

Have you suffered with any of this or a similar problem in the past? o No o Yes If yes how many times? \_\_\_\_\_ When was the last episode? \_\_\_\_\_ How did the injury happen? \_\_\_\_\_

Other forms of treatment tried: o No o Yes If yes, please state what type of treatment: \_\_\_\_\_, and who provided it: \_\_\_\_\_ How long ago? \_\_\_\_\_ What were the results. o Favorable o Unfavorable o please explain.

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have and N for Never have had:

\_\_\_ Broken Bone \_\_\_ Dislocations \_\_\_ Tumors \_\_\_ Rheumatoid Arthritis \_\_\_ Fracture \_\_\_ Disability \_\_\_ Cancer \_\_\_ Heart Attack \_\_\_ Osteo Arthritis \_\_\_ Diabetes \_\_\_ Cerebral Vascular \_\_\_ Other serious conditions:

PLEASE identify ALL PAST and any CURRENT conditions you feel may be contributing to your present problem:

HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES		
SURGERIES		
CHILDHOOD DISEASES		
ADULT DISEASES		

**SOCIAL HISTORY**

- 1. Smoking:  cigars  pipe  cigarettes How often?  Daily  Weekends  Occasionally  Never
- 2. Alcoholic Beverage: consumption occurs  Daily  Weekends  Occasionally  Never
- 3. Recreational Drug use:  Daily  Weekends  Occasionally  Never
- 4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 3- Activities of daily living

**FAMILY HISTORY**

- 1. Does anyone in your family suffer with the same condition(s)?  No  Yes  
If yes whom:  grandmother  grandfather  mother  father  sister's  brother's  son(s)  daughter(s)  
Have they ever been treated for their condition?  No  Yes  I don't know
- 2. Any other hereditary conditions the doctor should be aware of.  No  Yes: \_\_\_\_\_

I hereby authorize payment to be made directly to Stronghold Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Stronghold Chiropractic for any and all services I receive at this office.

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Completed

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Date Form Reviewed

## Activities of Daily Living/Symptoms/Medications

Patient Name: \_\_\_\_\_ File# \_\_\_\_\_ Date: \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

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

Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

List Prescription & Non-Prescription drugs you take: \_\_\_\_\_

\_\_\_\_\_

**Please mark P for in the Past, C for Currently have and N for Never**

- Headache     Pregnant (Now)     Dizziness     Prostate Problems     Ulcers  
 Neck Pain     Frequent Colds/Flu     Loss of Balance     Impotence/Sexual Dysfun.     Heartburn  
 Jaw Pain, TMJ     Convulsions/Epilepsy     Fainting     Digestive Problems     Heart Problem     Shoulder Pain  
 Tremors     Double Vision     Colon Trouble     High Blood Pressure     Upper Back Pain     Chest Pain  
 Blurred Vision     Diarrhea/Constipation     Low Blood Pressure     Mid Back Pain     Pain w/Cough/Sneeze  
 Ringing in Ears     Menopausal Problems     Asthma     Low Back Pain     Foot or Knee Problems     Hearing Loss  
 Menstrual Problem     Difficulty Breathing     Hip Pain     Sinus/Drainage Problem     Depression     PMS  
 Lung Problems     Back Curvature     Swollen/Painful Joints     Irritable     Bed Wetting     Kidney Trouble  
 Scoliosis     Skin Problems     Mood Changes     Learning Disability     Gall Bladder Trouble  
 Numb/Tingling arms, hands, fingers     ADD/ADHD     Eating Disorder     Liver Trouble  
 Numb/Tingling legs, feet, toes     Allergies     Trouble Sleeping     Hepatitis (A,B,C)

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**Auto Accident/Work Injury**

When was your most recent auto accident? \_\_\_\_\_

What speed was the collision? \_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_

Do you plan to claim this accident as a personal injury case (Check One)  YES  NO

When was your most recent strain / stress at work? \_\_\_\_\_

Please describe the manner of the injury: \_\_\_\_\_

Was treatment received? Please describe. \_\_\_\_\_

Does your job require you remain in long term stressful postures? \_\_\_\_\_  
(i.e. all day seating, repeated lifting, long term computer use)

Do you plan to claim this stress as worker's compensation? (Check One)  YES  NO

Spinal traumas in the past?  YES  NO If YES, continue and define what type of spinal trauma:

1. Collision, quick burst, or repetitive motion sports? (i.e. football, wrestling, basketball, baseball, soccer, tennis, golf, track and field) \_\_\_\_\_
2. Trauma as a child? (i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident) \_\_\_\_\_
3. Work around the house? (i.e. lifting, bending, woke up with stiff neck, "back went out") \_\_\_\_\_

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**Doctor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Stronghold Health NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

### PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders **-we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or up coming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

### YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

### COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. David Hausmann at (615) 730-8131. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days . If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Ave. SW  
Room 509F HHH Building  
Washington DC 20201

### Welcome to Stronghold Health!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read “Our Office Policies”, if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your *Application for Care*, please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone’s best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY** - Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Stronghold Health** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body’s innate wisdom. The doctors use 1) spinal corrective chiropractic adjustments OR 2) a myriad of techniques to accomplish this goal, including but not limited to manual cervical traction, nutritional support, neuro-muskuloskeletal re-education, prescribed exercises, postural warm up exercises and other active and passive care. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT’S REPORT OF FINDINGS** - To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a ‘Doctors Report of Findings’. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors’ recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient’s family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

**Cancellation Policy (For Report of Findings):** This appointment takes place after adjusting hours, and when we reserve space on our appointment schedule, our time and services are for you. This is the most important visit you will have at the office, as well as the most time you will spend with the doctor to go over your case and Doctor’s recommendations for care. If for whatever reason you cannot make this scheduled Doctors report, you must inform our office no less than 24 hours before that scheduled appointment time. Failure to do so results in a cancellation fee of \$50.

Patient initials: \_\_\_\_\_ -retaining pages 2 of 3

*Note: Patient retains the above Privacy Practice/Office Policies and STRONGHOLD HEALTH retains the signature sheet.*

I hereby acknowledge receiving a copy of 'Notice of Privacy Practice' and 'Office Policies' a three page document, the first two pages of which I have read and retained. This third page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' at a time in the future and will make the new provisions effective for all information that it maintains past and present. At this time, I do not have any questions regarding my rights or any of the information I have received.

*I hereby authorize and guarantee payment for all services rendered. Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received. In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 3.5% per month on any balance due, as well as all reasonable collection costs not to exceed 50% of the balance, court costs, attorney fees and interest fees accrued with the collection of this account.*

*If after 90 days of inactivity on my account, without prior communication of discontinuation of care or of cancellation, Stronghold Chiropractic reserves the right to withhold refunds at that time.*

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient or Authorized Persons Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness


\_\_\_\_\_  
Date

## Informed Consent

### REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:


I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Stronghold Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

\_\_\_\_\_ / \_\_\_ / \_\_\_  *Witness Initials*  
Patient or Authorized Person's Signature Date

### REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_ / \_\_\_ / \_\_\_  *Witness Initials*  
Patient or Authorized Person's Signature Date

**FEMALES ONLY** → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

- The first day of my last menstrual cycle was on \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date
- I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.