Christian B. Carlstrom, D.C.
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Phone (561) 741-1316
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APPLICATION FOR CARE:

Patient First Name: _____ Last Name: _____

Address: Street_____City_____St_____Zip_____

Home Phone: (___) _____ Cell Phone: (___) _____

Work Phone: (___) _____ Email Address: _____

Out of State Address: _____ Phone: (__)_____

No. of Children and Ages: _____ Driver's License#:_____

Sex: O Male or O Female Status: O Married O Single Spouse's Name: _____
O Widowed O Divorced Spouse's Employer: _____

(Federal info needed)
Language spoken: _____ Race: White Black Asian American Indian Decline Other_____
Ethnicity: Hispanic or Non Hispanic or Decline

Date of Birth ____/____/_____ Age: _____

Whom may we thank for referring you to us? _____

EMPLOYMENT

O Full Time O Part Time
O Retired O Not Employed

STUDENT

O Full Time O Part Time
O Non Student

Patient's Employer: _____

Address: _____

City, State, Zip code: _____

Phone: (__) _____ Occupation: _____

INSURANCE INFORMATION:
Primary Insurance Company Name
_____

Membership# _____Group# _____

Complete only if Patient is not the Insured:
Insured's Name: _____
Birth Date: ___/____/____ Sex O M or O F
Patient's relationship to Insured:
_____

INSURANCE INFORMATION:
Primary Insurance Company Name
_____

Membership# _____Group# _____

Complete only if Patient is not the Insured:
Insured's Name: _____
Birth Date: ___/____/____ Sex O M or O F
Patient's relationship to Insured:

AUTOMOBILE ACCIDENT / WORKER'S COMPENSATION ONLY:
Insurance Company Name: _____ Claim#: _____

Adjuster's Name: _____ Phone# (___) _____ext: ____

Attorney's Name: _____ Phone# (___) _____

Do you have a Health Savings or Flex Spending account? _____
If so, how much is available to use for your care in your account? _____

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Confidential Patient Information

Primary Complaint/Reason for appointment	Date condition started or for how long:	Have you had this before?	Injury related related?
1. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			
2. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			
3. _____	_____	Yes / No	Yes / No
Please circle pain scale (no pain) 0 / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 (worst pain)			

What other treatment options have you tried for these conditions?_____

If this is a work or auto injury, please notify the receptionist now. Work _____ Auto_____ other_____
Have you lost work from above condition(s)? ☐ Yes ☐ No If yes, give dates: from _____ to _____

All current medications: NONE or 1._____2._____3._____
Allergies to any medications: (please list medication and allergic reaction when taken): NONE or 1._____
2._____ 3._____
All previous surgeries and dates:_____
Do you smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No Height_____ Weight_____
Do you exercise? ☐ Yes ☐ No If yes, how often?_____ Blood Pressure:_____/_____
Are you interested in a complimentary Body Fat/Body Composition analysis? **☐ Yes ☐ No**

How is your current problem affecting your hobbies?_____

Medical Doctors consulted in the past year:
Name:_____ Date:_____ Reason:_____
Name:_____ Date:_____ Reason:_____
Chiropractic Doctors or Physical Therapists consulted in the past year:
Name:_____ Date:_____ Reason:_____
Date of last spinal x-rays:_____ How long were you under care?_____
FEMALES: Is there a possibility of you being pregnant? ☐ Yes ☐ No ☐ Unsure

Please circle the following conditions you may have had in the past or have now:

Headaches	Arthritis	Insomnia	High Blood Pressure	Digestive Problems
Migraines	Other Joint Pain	Stroke	Blood Vessel Disease	Ulcers
Neck Pain	Numbness	Vision Changes	Menstrual Cramps	Constipation
Shoulder Pain	Joint Swelling	Nose Bleeds	Irregular Periods	Urinary Problems
Arm/Hand Pain	Scoliosis	Ringing in Ears	Allergies	Kidney Problems
Mid Back Pain	Flat Feet	Earaches	Asthma	Gallbladder Problems
Low Back Pain	Dizziness	Hearing Loss	Cancer	Tuberculosis
Hip Pain	Nausea	Cough	Osteoporosis	Gout
Leg/Foot Pain	Weakness/Fatigue	Chest Pains	Diabetes	Depression
Disc Problems	Nervousness	Heart Problems	Hypoglycemia	Other_____

*****Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Your doctor will weigh your needs and desires when recommending your treatment program.***

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Relief Care **☐ Corrective Care** **☐ Doctor will select appropriate care for condition.**

Relief Care

Relief care gets rid of symptoms or pain, but not the cause of it. Initial problem is likely to return.

Corrective Care

Corrective care differs from relief care in that the goal is to get rid of symptoms AND correct the cause of the problem.

Consent for Treatment

I hereby give my consent for the doctors and staff of Spine Design Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) such as (a scanned copy will serve as original):

release of information to family physicians and employer.
release of information to insurance companies.
the taking of photographs and x-rays to be used for treatment purposes.
the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize assignment of my insurance benefits to be paid directly to:

Spine Design Chiropractic (Carlstrom Family Chiropractic Center, P.A.)
1102 W. Indiantown Road, Suite 11
Jupiter, FL 33458
561-741-1316

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees 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 these fees.

Payment Policies

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.
Method of payment for today's charges will be: □ Cash □ Check □ Visa/MC □ AmEx □ Discover

2. At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

Patient's Signature:_____ Date:_____

Guardian's Signature:_____ Date:_____

Consent to Treatment of Minor Child

I hereby authorize Spine Design Chiropractic to administer treatment as they so deem necessary to my

son/daughter/other,_____ (name)

Date:_____ Signed:_____

TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: *to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.*

Adjustment: *the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is 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 vertebrae 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 God-given ability to express its maximum health potential.*

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

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's God-given wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____ have read and fully understand the above statement.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
(signature) (date)

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

SPINE DESIGN CHIROPRACTIC

I, _____ (Patient name) have read a copy of Spine Design Chiropractic's

Notice of Patient Privacy Practices.

_____ _____

Signature of Patient or
Parent or legal Guardian

Date

HOW OUR OFFICE WORKS…

We want to provide you with the highest level of service possible so please read the following information about how our office works.

PATIENT PRIVACY – The majority of our patient care takes place in a semi-private setting so please be aware that many of our conversations are overheard by other patients**. If you need to discuss something confidential we will schedule a time for you to speak to the doctors in a private consultation room when the need arises.** Our adjusting room doors can be closed to provide some privacy while you are getting adjusted.

YOUR CARE – When a patient seeks care in our office and we agree to provide that care, it is essential for the doctor and patient to be working toward the same objective. Chiropractic care at Spine Design Chiropractic is rendered to correct subluxations (spinal misalignments) and postural dysfunction, which are a major interference of the body's ability to express optimal health. Your doctor will outline a course of treatment to take you beyond simple pain relief, to structurally correct your spinal problems and enable the central nervous system to function optimally, improving overall health.

FIRST THINGS FIRST – Prior to receiving chiropractic care in our office, a health history and exam will be completed and x-rays will be taken to confirm the true nature of your condition. These findings will aid the Doctors in determining the type and amount of care you will need. All of these findings will be reported back to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our goal is to correct your spinal issues and teach you how to maintain better health for a lifetime.

DOCTOR'S REPORT – To enhance your understanding of our chiropractic approach, you will be scheduled for a Doctor's Report to review the results of the initial examination we perform. Attendance is required for anyone who wishes to become new patients of our practice. We strongly urge you to invite your spouse or significant other to attend. From our experience, families that support each other in restoring their health through chiropractic care get better results. This is the only time we ask you to come at a specific time and you will be very enlightened about how to achieve and maintain optimal health naturally! We do not charge you for this appointment. Yes, it's that important!

Name_____ Date_____

Signature_____