## APPLICATION FOR CARE AT ARIZONA LIFE CHIROPRACTIC CENTER, LLC

Today's Date: _____

### PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
E-mail Address: _____ Home Phone: _____ Cell Phone: _____
Work Phone: _____ Social Security #: _____
Employer: _____ Occupation: _____
Name of Spouse: _____ Spouse's Employer: _____
Names and Ages of your children: _____
_____
Name & Number of Emergency Contact: _____ Relationship: _____

***Whom may we thank for referring you to this office →** _____

### HISTORY of COMPLAINT(s)

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office:

**Primary problem** _____ **2nd** _____ **3rd** _____

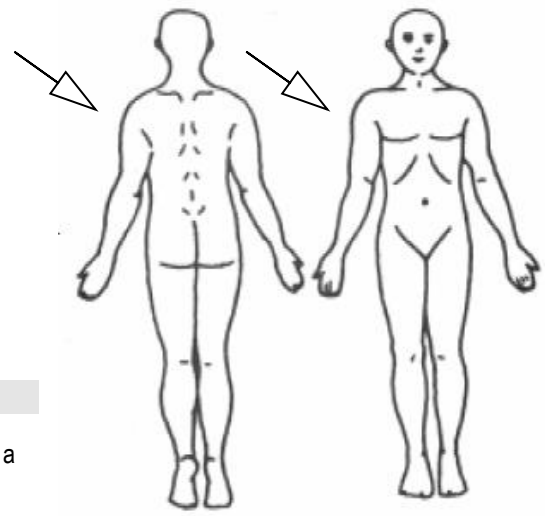
When did each **problem/symptom begin**: Primary complaint _____ 2nd _____ 3rd_____
Number of times you have experienced: Primary complaint _____ 2nd _____ 3rd_____
When was the last **episode**? Primary complaint _____ 2nd _____ 3rd_____
What relieves your symptom(s)? Primary complaint _____ 2nd _____ 3rd_____
What makes them feel worse? Primary complaint _____ 2nd _____ 3rd_____

Please mark with a "**C**" if you feel your pain constantly or an "**I**" if you experience it intermittently on the line next to each compliant:
Primary problem ___ 2nd complaint ___ 3rd complaint ___

On a scale of **1 to 10** with **10** being the worst pain and **0** being no pain, rate **how you feel today** ***(Circle the number)***:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Primary** or chief complaint | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Second** complaint | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Third** complaint | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
**R = R**adiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



Do your symptoms cause you to feel worse in the ☐ AM ☐ PM ☐ mid-day ☐ late PM
Have these Problems ever been treated by anyone in the past? ☐No ☐Yes **If yes**
**Who** provided: _____
**How long ago?** _____What **type** of treatment did you receive? _____
**What** were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:
_____
List any **medications** taken to treat these conditions:_____
Did they help? ☐ No ☐ Yes If you still take them, how often? _____
Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____
Name of Previous Chiropractor: _____
Are any of your problem(s) today the result of ANY **recent accident**? ☐ No ☐ Yes **If yes,**
How long ago? _____ Please explain what type of accident: _____

### PAST HISTORY

**1.** 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:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Seizure
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis
___ Osteo Arthritis ___ Fracture ___Diabetes ___ Other serious conditions {*Doctors add other possible contraindications here*}

**2. PLEASE, identify ALL PAST and any unrelated current conditions you feel may be contributing your present problem:**

| | HOW LONG AGO | TYPE OF CARE RECEIVED | BY WHOM |
|---|---|---|---|
| **PREVIOUS ACCIDENTS →** | | | |
| **ADULT DISEASES →** | | | |
| **SURGERIES →** | | | |

**Reserved for doctor's use only → Systems reviewed with patient**:

❑Musculoskeletal ❑ Other
❑Neurological ❑ Other

## 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. How** many years of school did you complete? ❑ 1-8 ☐ 8-12 ☐12-14 ☐14-16 ☐ 16 +

**5. Hobbies -Recreational Activities- Exercise Regime:** How does you present problem affect the following:

**IDENTIFY TYPE:** **EFFECT**

_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform
_____ ☐ No Effect ☐ Painful (can do) ☐ Painful (limits) ☐ Unable to Perform

**6. Work Activities**: Please complete **all** questions or mark with N/**A** for 'does *not apply*' **!**
**Hours** worked per day: _____ Days per week: _____
Does your job require **lifting**? ☐ No ☐ Yes If yes, what is the maximum required? ☐ < 5 lbs ☐ 5-20 lbs ☐ 20-50lbs ☐ > 50 lbs
**Lifting Frequency:** ☐ Constant (66-100%of day) ☐ Frequent (33-66% of day) ☐ Occasional (0-33% of day)
**Lifting Postures:** ☐ Knee ☐ Torso ☐ Arm ☐ Shoulder ☐ Off Posture
Standing: _____ Hrs per day Sitting: _____Hrs per day Pushing: _____ Hrs per day
Twisting: _____ Hrs per day Climbing: _____Hrs per day Pulling: _____ Hrs per day
Kneeling: _____ Hrs per day Reaching: _____Hrs per day Walking: _____ Hrs per day

**7. Repetitive Activities:**
Computer: _____ Hrs per day Grasping: _____ Hours per day Hand Tools: _____ Hrs per day
Machinery: _____ Hrs per day Assembly: _____ Hrs per day Phone: _____ Hrs per day
Other: _____ _____ Hrs per day

**8. What Impact does your present problem have on your ability to work:** ☐ No Effect ☐ Painful ☐ Limits ☐ Unable
**9.** How does your problem affect your ability to carry out activities of daily life? ☐ No Effect ☐ Painful ☐ Limits ☐ Unable

## 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)
**2**. Have they ever been treated for their condition? ❑ No ❑ Yes ❑I don't know
**3. Any** other hereditary conditions the doctor should be aware of ❑ No ❑Yes _____

◆◆◆◆◆

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

I understand the risks associated with chiropractic spinal adjustments, and the other therapeutic procedures enlisted at this by the doctor(s) in practice all my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration I do hereby consent to chiropractic care by any means, methods, and or techniques the doctor deems necessary to treat my condition(s) at any time throughout the entire clinical course of my care.

_____ ____ - ____ - ____
Patient or Authorized Person's Signature Date Completed

**Reviewed by**: _____ ❑ Interviewer Initials _____ ❑ Doctors Initials

arizona life
chiropractic center
4150 W Peoria Ave Ste 134
Phoenix AZ 85029 602.242.7537
**Dr. Dennis Cathcart**

Massage Clients/Patients

**If you need to cancel your scheduled massage for any reason…**

**We REQUIRE a 24 - hour notice…**

***(if you need to cancel/change a Monday massage, Please leave a voicemail or text to 602.242.7537, it will date and time stamp it to waive your fee)***

**…OR you will be assessed a**

**$25 *cancellation/no-show* fee for 1 hour massage**

**$35 *cancellation/no-show* fee for 1 ½ hour massage**

**which you will be required to pay before we can schedule your next massage.**

This policy is out of courtesy to our Massage Therapist, (she blocks out an entire hour or more for our patients, to help you heal and feel better, so if you no-show, that is an entire hour someone else could be receiving help from her healing massages.) She is extremely busy so please make every effort to keep your appointment time, as it may be a while before there is another opening.

Thank you for your understanding.

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*I agree and understand that if needed, I will make changes or cancellations for my scheduled massage appointment at least 24 hours before my scheduled appointment by calling 602.242.7537 and leaving a message or text or of course in person.*

*If I do not notify Arizona Life Chiropractic of my need to cancel at least 24 hours before my appointment, I agree to pay the $25 or $35 fee assessed for this service, depending on the time I scheduled.*

_____

Patient/Client Name Date

_____

Witness Date

# ARIZONA LIFE CHIROPRACTIC CENTER

# INFORMED CONSENT TO TREAT

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.

◆❖◆

I understand the Treatment Objectives as well as the risks associated with chiropractic adjustments. All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks 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.

☐ Allow my minor child to be treated by any means, method, and or techniques, the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of their care.

_____ _____

Patient or Authorized Persons Signature Date

_____ _____

Witness Date

# Arizona Life Chiropractic Center
# Office Policy

***Welcome to our office. Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.***

**Referrals:** The greatest honor a patient can give to their doctor is the referral of their family and friends. We promise to give your loved ones the same quality, love, and attention that you receive. Thank you in advance!

**Health Talk:** All new patients are required to attend ONE "Health Talk" workshop with their spouse or guest within the first four weeks of starting their care. These dynamic sessions will help you enhance your understanding of chiropractic care, answer your questions, teach you how to stay healthy naturally, and help you get the best results.

**Preferred Hours:** In order to provide the care you need as conveniently and rapidly as possible, we ask that you save detailed questions until your "Health Talk" workshops, or set up a special time to talk to Dr. Cathcart.

**Appointment Scheduling:** To save time we ask that you Pre-Schedule all of your appointments in advance. Please refrain from repeatedly rescheduling appointments within 24 hours.

**Financial Agreements:** It is your payment that allows us to continue providing high levels of professional care, maintain our facility, and pay our staff. If for any reason you can't keep your financial arrangement, inform us immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements.

**Terminating Your Care:** In the event you choose to discontinue your care for any reason, or we regretfully find it necessary to discharge you from our care, any outstanding fees become immediately due and payable.

**Occasionally** it is necessary for Dr. Cathcart to travel away from the office for conferences, continuing education, seminars, or vacation. So that you may continue with your recommended adjustment schedule, it may be necessary to schedule make up visits before or after the time that will be missed.

**Discouragement:** Remember that healing and spinal correction takes time. If any time during your care you do not feel that you're responding as well as you expected, please discuss it immediately with the doctor. We want you to get the most from your Chiropractic care!

I, _____, have read and fully understand the above policies and agree to abide by them.

_____ _____ _____

Signature Witness Date