PATIENT APPLICATION SURVEY

If you require more space for any of these answers, please note with "□" and use the back side of this form or attach additional information. Please complete this application in pen.

Today's Date _____

First Name _____ Middle Name _____

Last Name _____ Suffix _____ Nick Name _____

Age _____ Date of Birth _____

Sex □ F □ M □ Other Gender □ F □ M □ Other Pronouns □ He/His □ Her/Hers □ They/ Them

Address: _____

Apt # _____ City _____ State_____ Zip_____

Cell Phone _____ Home Phone _____

Email _____

Best place to reach you □ Home □ Cell □ Email

If necessary, may we leave a message for you at any of the above numbers? □ Yes □ No

Employment Status □ Employed □ FT Student □ PT Student □ Other □ Retired □ Self Employed

Marital Status □ S □ M □ W □ Have a 'significant other'

Name (First/Last) of Spouse / Partner / Significant Other_____

Emergency Contact Name _____ Phone Number _____

Who referred you to our office? / How did you find out about our services? _____

* I (signature) _____ consent to allow Dr. Puckette to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for care at Puckette Integrative Healthcare and also to determine if he is willing to accept my case. Parent or Legal Guardian (signature) _____

PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT:

(#1 is your chief complaint, #2 is of secondary importance, etc.)

1) _____ 2) _____ 3) _____ 4) _____

What % of the day does your chief complaint (#1) bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE ANSWER THE FOLLOWING QUESTIONS AS RELATED TO YOU CHIEF COMPLAINT (#1 listed above)

How long have you had this problem? _____ Did your symptoms begin suddenly? □Yes □No

Considering the amount of discomfort you've had THIS week, how long has your problem been this severe? _____

Is this problem related to an auto accident / work injury? □ Yes □ No If so, when & describe: _____

_____

Have you had an auto accident / or work injury in the last 7 years? □Yes □ No

Do you have any accident claims currently open for any reason? □Yes □No Describe: _____

If you can, describe any activity change, event, or accident that occurred around the time of the onset of your symptoms which may have contributed to your symptoms? (Include any significant emotionally stressful situations.) _____

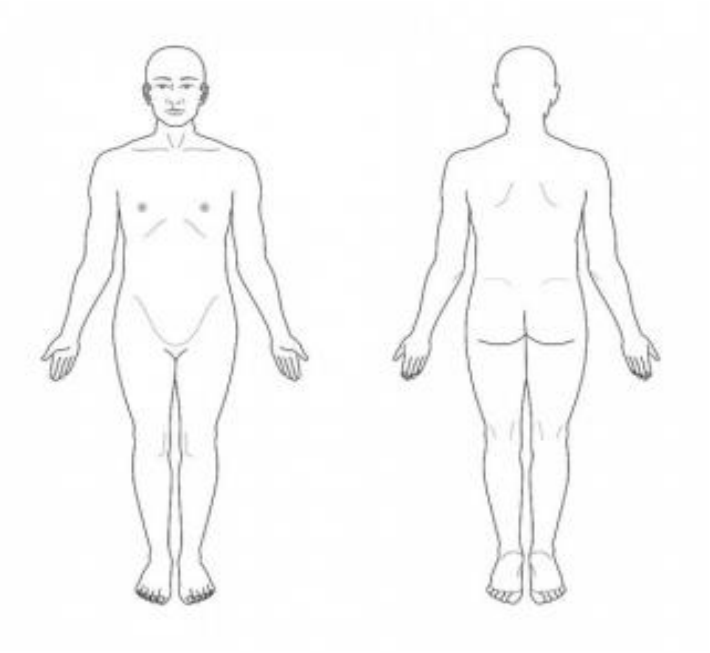
_____

_____

_____

All Patients:

Use the diagram below to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain/discomfort in the margins and connect with arrow to each area the description applies to.



Please circle the appropriate number(s) for the intensity of your pain when aggravated and the letter(s) For the frequency of the pain

0 = Occasional (0-25% of the time) I = Intermittent (26-50%) F = Frequent (51-75%) C = Constant (76-100%)

Area of Pain/Issue	Normal	Minimal	Slight			Moderate			Severe			Frequency			
												25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Upper Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Middle Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Lower Back		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Hips L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Shoulders L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Arms L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Leqs L R		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Headaches		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Dizziness/Vertiqo		1	2	3	4	5	6	7	8	9	10	O	I	F	C
Other:		1	2	3	4	5	6	7	8	9	10	O	I	F	C

Regarding you chief complaint, on a Scale of 0-10 (10 = Unbearable, 0 = No Discomfort) Please rate the following:
The HIGHEST your pain/discomfort gets WITHOUT medication _____ WITH Medication _____
The LOWEST your pain/discomfort gets WITHOUT medication_____ WITH Medication _____

PAST TREATMENT HISTORY

Nutritional Supplements

Name of supplement	Company	Amount	Reason for taking	How long?

Prescription Medications

Name of prescription	Amount	Reason for taking	How long?

Epidural: How Many_____ When _____

Physical Therapy: How Long _____ When _____

Chiropractic Care: How Long _____ When _____ Where_____

If so, please briefly explain your likes and dislikes _____

_____

_____

_____

Did any of these treatments work? If so, which one(s)? For how long?

_____

_____

_____

Other than routine checkups, <u>for what conditions</u> have you sought medical attention and <u>from what specialist</u> and when? How did you respond?

_____

_____

_____

_____

Have you received other diagnostic tests? □ Yes □ No. Type and results: _____

_____

_____

_____

Have you received any X-rays, MRIs, Blood Analysis/Blood testing within the past 18 months? □ Yes □ No

– Please bring a copy of the results to your consultation.

Injuries/surgeries you have had:

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Auto Accidents _____

Other _____

Have you experienced any anaphylactic reactions? □ Yes □ No

If so, please describe _____

Allergies:

Please list all allergies you have to food, drugs, or other substances, along with the symptoms they produce and indicate how long you have suffered from each:

Allergy Symptoms How long?

Surgeries:

Please list all surgeries you have had, including the date, why it was done, and any complications: Date Surgery Why done? Complications

Family History

Relationship	Age (Now or death)	Alive/Deceased	Diseases	Serious illness or cause of death
Father		□ alive □ deceased	□no significant disease □has/had _____	
Paternal grandfather		□ alive □ deceased	□no significant disease □has/had _____	
Paternal grandmother		□ alive □ deceased	□no significant disease □has/had _____	
Mother		□ alive □ deceased	□no significant disease □has/had _____	
Maternal grandfather		□ alive □ deceased	□no significant disease □has/had _____	
Maternal grandmother		□ alive □ deceased	□no significant disease □has/had _____	
Brother(s)		□ alive □ deceased	□no significant disease □has/had _____	
Sister(s)		□ alive □ deceased	□no significant disease □has/had _____	
Son(s)		□ alive □ deceased	□no significant disease □has/had _____	
Daughter(s)		□ alive □ deceased	□no significant disease □has/had _____	

Please check if you have had any of the following:

Childhood Illnesses:

- ☐ ADD
- ☐ Allergies/Hay fever
- ☐ Anemia
- ☐ Asthma
- ☐ Bedwetting
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Headaches
- ☐ HIV
- ☐ Lyme Disease
- ☐ Measles
- ☐ Rash/Psoriasis
- ☐ Scoliosis
- ☐ Other: _____

Adult Illnesses:

- ☐ ADD
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Colitis
- ☐ CRPS(RSD)
- ☐ CVA(Stroke)
- ☐ Kidney Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Eye Problems
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Influenza
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus Erythema
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pleural Effusion
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Seizures
- ☐ Shingles
- ☐ STD's (Unspecified)
- ☐ Suicide Attempt(s)
- ☐ Thyroid Problems
- ☐ Vertigo
- ☐ Other: _____

Other Symptoms/ Illnesses:

- ☐ Difficulty starting/stopping/ controlling/ urine flow
- ☐ Numbness around the seated area *I* anus
- ☐ Spinal Disc Space Infections
- ☐ Fractures due to osteoporosis
- ☐ Chronic use of steroids or narcotics
- ☐ Bowel Movement Difficulty
- ☐ Diagnosed with Abdominal Aortic Aneurysm
- ☐ Osteoporosis
- ☐ Diagnosis of Spinal Stenosis
- ☐ Coughing *I* Sneezing *I* laughing increases back *I* leg pain (Circle applicable)
- ☐ Recent compression fracture? Where? _____

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. **Please check as many that apply; add additional comments in the margin or on the back as needed.**

How have others been affected by your health condition? □No one is affected □haven't noticed any problem
□If they tell me to do something □People avoid me □Other:_____

What are you afraid this might be (or is beginning) to affect (or will affect) in any way?
□Energy □Your mood / attitude □Stress □Job □Kids □Future ability □Marriage
□Any relationships (frequency visiting, quality, etc.) □Self-esteem □Sleep □Time
□Finances □Freedom □Other: _____

Are there health conditions you are afraid this might tum into?

□Family health problems □Heart disease □Diabetes □Arthritis □Fibromyalgia □Depression □Chronic Fatigue
□Need surgery □other: _____

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:_____

_____

_____

_____

_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
Try to give 3 examples: _____

_____

_____

_____

What are you most concerned with regarding your problem? _____

_____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

_____

What would be different/better without this problem? Please be specific

_____

What do you desire most to get from working with us? _____

_____

_____

SELF ASSESSMENT & TREATMENT GOALS

Although you are not a specialist, what, in your opinion, do you think the real problem is?

_____

_____

Do you blame anyone or hold anyone partially responsible for your current condition or for making your condition worse? (Be specific) _____

_____

_____

Would you consider this problem (check one):

☐ SLIGHT (Tolerable but causing a little limitation)

☐ SEVERE (Causing significant limitations and/or concern)

☐ MINIMAL (Annoying but causing NO limitations)

☐ MODERATE (Sometimes tolerable but causing limitations)

☐ EXTREME (Causing near constant limitations, >80% of the time)

Which best describes your health goals:

☐ Pain Relief Only (not interested in correction of the problem).

☐ Would like to find the cause of this problem and have it improved or corrected.

How strong is your desire to correct this problem ☐ Mild ☐ Moderate ☐ High ☐ Extremely High

☐ Wellness / Preventative care – I want to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be specific)

_____

_____

_____

_____

What is YOUR idea of an ideal doctor?

_____

_____

_____

Based on your complementary consultation, history and exam findings, you may require additional tests that require payment at time of service. If this is required, you will be informed in advance.

I, _____ (Please Print Full Name), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. I understand that failure to complete this application fully and review the enclosed material may mean that the doctor will not be able to conduct the consultation and evaluation. I will also bring any labs, images or reports which have been requested in this application. I give this office permission to communicate with me via mail, telephone, and email.

I understand that Puckette Integrative Healthcare offers an alternative holistic treatment approach to support my general health, not a cure for a specific diagnosis. By identifying and addressing areas of neurological and physiological imbalances, and supporting those areas, areas of dysfunction can be improved upon as well as overall health. I further understand that if I choose to be treated at Puckette Integrative Healthcare, I am to continue to follow the treatment plan of my medical doctor and stay on all of my prescribed medications. Any changes to my medical treatment plan or to my prescription medications will ONLY be made by my medical doctor, NOT by Dr. Puckette.

Signature: _____ Date: _____

Fragrance Free

As a courtesy to our patients, and Doctor, with acute sensitivities to allergens, please refrain from using any scented products prior to your visit. A single exposure to lingering scents can trigger strong physical reactions or migraines that last for days in people who are chemically sensitive.

This office policy refers to perfumes, colognes scented deodorant, scented skin or hair care products, AND essential oils.

As powerfully as essential oils can help when it is the right one for you, they can be equally detrimental to those who have a sensitivity to any of them.

I have read and agree to the above policy.

Name Date

Office Policies

At Puckette Integrative Healthcare, we strive to provide quality care in a timely matter. We have implemented the following policies which enable us to better utilize available appointment times for our patients in need.

1) If it is necessary to cancel and reschedule your appointment, we require that you give at least 24 hours' notice. Available appointments are on high demand and giving early notice allows another patient to fill that time. If you fail to give a 24 hour notice a $25.00 fee will be charged to your account. The patient is held responsible to this charge as we do not bill late fees.
2) A "No Show" is someone who misses an appointment without cancelling it. No shows inconvenience those individuals who need access to our care. A $25.00 fee will be charged to your account.
3) If a patient is late, they will be seen as soon as possible. Because of the late arrival we ask that you keep your appointment short as this will affect the other appointment times.
4) Integrative healthcare is a stance that looks at your whole body's system and how to improve all different aspects that affect your health. This means we do different types of appointments. Because of this structure we ask that you keep you appointment dedicated to the assigned appointment type. This means when you are in for an adjustment, you save your neurological or nutritional questions for before or after your appointment by leaving a message with the front desk, emailing, or calling the doctor directly. He will get your message and respond at his earliest convenience.
5) If a patient is more than 15 minutes late, the appointment will be cancelled and will have to be rescheduled. A $25.00 fee will be applied to your account.
6) We have the right to refuse treatment and or terminate care due to any inappropriate behavior toward other patients or staff.

To cancel or reschedule your appointment please call (608) 276-7635

I have read and understand Puckette Integrative Healthcare's Office Policies and agree to the terms.

_____ _____

Printed Name Date

_____ _____

Patient or Legal Guardian Signature Relationship

Patient Request for Email Communication

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

Communication over the internet or using email services may not be secure. There is no assurance of confidentiality when communication over the internet. To request that this provider communicate with you via email, you must complete this form and return it to the office.

Please be advised that:

1) **This request applies only to Puckette Integrative Healthcare. If you would like to request to communicate with another facility you must complete a separate form for that office.**
2) Puckette Integrative Healthcare will not communicate health information protected by federal law (i.e. HIV/AIDS, substance abuse, mental health information).

I understand and agree to the following:

1) I certify that the email provided is accurate and I accept full responsibility for the messages sent to and from this address.
2) I understand the internet is not a secure source of communication, there is no assurance of confidentially when communicating via email.
3) I agree to hold Puckette Integrative Healthcare and all individuals with it harmless from and all claims and liabilities arising from or related to this request to communicating via email.

_____ _____

Printed Name Date

_____ _____

Patient or Legal Guardian Signature Relationship

HIPAA PRIVACY INFORMATION

By signing below I agree that I have had the opportunity to read the office's HIPAA privacy regulations and patient's rights and have been offered a copy of them for my records.

All my questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____

Patient Name

_____ _____

Patient or Legal Guardian Signature Date

_____

Staff Initial

Patient Health Information Consent From

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow his chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained on time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained on patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient Name

_____ _____

Patient or Legal Guardian Signature Date