Provider: 1134265150

Patient Application

Welcome to our office!!

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.
Please fill out the following information **thoroughly** so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need any assistance.

We look forward to serving you!!

Today's Date ____ / ____ / ______ Patient ID Number: _________(last four digits of your social security number)

Name ________________________________ Age _______ Birth Date: ____ / ____ / ______ Sex M F

Address ____

City _____________________ State __________ Zip ________ Email ___________________________________

Home Phone __________________ Work Phone __________________ Cell Phone ____________________

Best Place To Reach You (Circle One) Home / Work / Cell May we leave a voicemail message for you? Yes / No

Employer ________________________ Occupation ____________________ Length of Employment _________

Type of Work (Circle One) Office/Clerical Light Labor Moderate Labor Heavy Labor

SS# ___________________ Marital Status S M W D Spouse's Name ________________________________

In Case of Emergency: Contact Name __________________ Relationship ____________ Phone # _________________

How Did You Hear About Us? ____

Who Is Your Primary Care Physician? ____

How Serious Do You Think Your Problem Is? _______________________________________

List Anything You May Be Allergic To: ____

FOR WOMEN ONLY:
Do You Take Birth Control? Yes No If Yes, For How Long? ________________

Are You Nursing? Yes No Are You Pregnant? Yes No Delivery Date? ______________

Purpose Of This Visit: (Main Patient Complaint) ________________________________

The Reason For This Visit Is A Result Of (Please Circle):

Auto Accident Work Injury Trauma Sports Gradual Onset Chronic Other (Explain) _______________

Date Of Injury/When Did The Condition Begin? ______________________________________

Is The Condition Getting Worse (Circle One)? Yes No

Please Explain What Happened:

____

____

____

____

____

What activities aggravate your symptoms? ____

Is there anything that has relieved your symptoms (Explain): _________________________________

Is This Condition Interfering With Your (Please Circle):

Work Sleep Daily Routine Activities Hobbies Sports/Athletics Exercise Other: ________________

Who have you seen for this? ____

What did they do and how did you respond? ____

Experience With Chiropractic:

Have you seen a Chiropractor before? Yes No Who did you see? ____

Reason for visits? _______________________ How did you respond? ____

Did you know your posture determines your health? Yes No

Are you aware of any of your poor postural habits? Yes No Explain: ____

The most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward, weakening your whole body,) where even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or feel like you carry your head forward? **YES NO**

Health Lifestyle:

Do you exercise? Yes No What activities? _______________________ How frequently? ___________________

Do you drink caffeinated products (coffee, tea, soda, etc.)? Yes No Occasionally, often, or never? _______________

Do you take any supplements (i.e. vitamins, minerals, herbs)? Yes No Please list: _____________________________

Body Diagram:

Using the key below, please indicate on the body diagram where you are experiencing the following symptoms:

H = Sharp

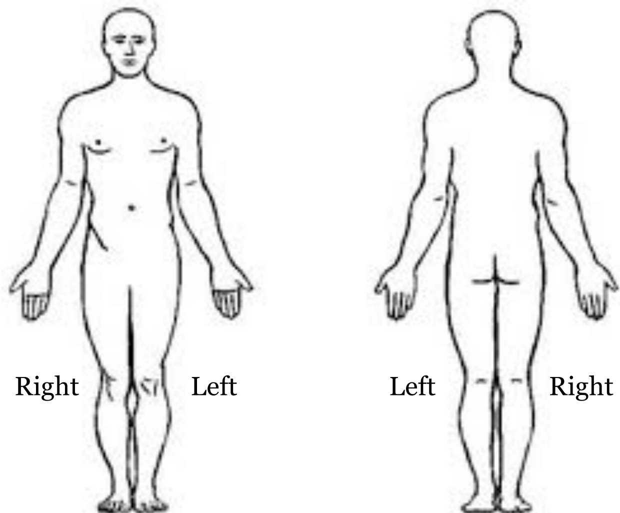
N = Numbness

B = Burning

S = Stabbing

T = Tingling

A = Dull Ache



When did your symptoms begin? ______________

How often do you experience your symptoms (Circle One)?

Constantly (76-100%) Frequently (51-75%) Occasionally (26-50%) Intermittently (0-25%)

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Health Conditions

Cervical Spine (Neck):

Postural distortions from subluxations (or misalignments) in your neck cause Forward Head Syndrome, will weaken the nerves into your arms, hands and head, and will affect these parts of your body. Do you experience...?

Yes	No	Neck Pain	Yes	No	Headaches
Yes	No	Pain into your shoulders / arms / hands / fingers	Yes	No	Dizziness
Yes	No	Sinusitis	Yes	No	Recurrent Colds / Flu
Yes	No	Allergies / Hay Fever	Yes	No	Visual or Hearing Disturbances
Yes	No	Numbness / Tingling in arms / hands / fingers	Yes	No	TMJ Pain / Clicking
Yes	No	Coldness in hands / fingers	Yes	No	Low Energy / Fatigue
Yes	No	Weakness in grip	Yes	No	Thyroid Conditions

Thoracic Spine (Upper Back):

Postural distortions from subluxations (or misalignments) in the upper back will weaken the nerves to your heart and lungs and affect these parts of your body. Do you experience...?

Yes	No	Upper back pain	Yes	No	Recurrent lung infections / Bronchitis
Yes	No	Heart murmurs / Palpitations	Yes	No	Asthma / Wheezing
Yes	No	Tachycardia	Yes	No	Shortness of breath
Yes	No	Heart attacks / Angina	Yes	No	Pain upon deep inhalation / exhalation

Thoracic Spine (Mid Back):

Postural distortions from subluxations (or misalignments) in the mid back will weaken the nerves to your ribs, chest, and upper digestive tract, and affect these parts of your body. Do you experience...?

Yes	No	Mid back pain	Yes	No	Hypoglycemia
Yes	No	Indigestion / Heartburn	Yes	No	Pain into your ribs / chest
Yes	No	Nausea / Reflux	Yes	No	Ulcers / Gastritis
Yes	No	Tired/irritable after eating or when haven't eaten for a while			

Lumbar Spine (Lower Back):

Postural distortions from subluxations (or misalignments) in the lower back will weaken the nerves to your legs, feet, and pelvic organs and affect these parts of your body. Do you experience...?

Yes	No	Low back pain	Yes	No	Muscle cramps in your legs / feet
Yes	No	Constipation / Diarrhea	Yes	No	Weakness/injuries in hips / knees / ankles
Yes	No	Pain into hips / legs / feet	Yes	No	Sexual dysfunction
Yes	No	Numbness / tingling in legs / feet	Yes	No	Coldness in legs / feet
Yes	No	Recurrent bladder infections	Yes	No	Frequency / difficulty urinating
Yes	No	FOR WOMEN ONLY: Menstrual irregularities / Cramping / Infertility / Pregnancy Complications			

Patient Name: ______________________________ Date: ___ / ___ / _____

Health Conditions Continued

Please list any health conditions not mentioned: ____

____

Please list any medications / surgeries (including date): ____

____

Please list any traumas you sustained (falls, car accidents, etc.): _______________________________________

____

Authorization of Care and Assignment of Benefits

I certify that the information I provided above is true and accurate.

I authorize and agree to allow Dr. Steve Lininger, LLC to work with my spine and extremities through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I understand that Dr. Steve Lininger, LLC will submit claims on my behalf to my insurance for services rendered; however, it is my responsibility to ensure that these claims are paid for in full and on time.

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health care or Medicare. I authorize the assignment of all insurance benefits be directed to Dr. Steve Lininger, LLC for all services rendered. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Not withstanding denial, reduction of benefit or failure to pay for any reason, I understand that I am responsible for all remaining charges.

The Doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.
I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

I understand that I will be responsible for a charge of $25.00 for missed appointments without at least 24 hours prior cancellation notice. I understand that this fee is not covered by insurance, and will be billed to me directly.

HIPAA WAIVER: I, the undersigned patient, understand that my signature on the sign-in sheet may be viewed by other people in the course of a normal operations day here at the office of Dr. Steve Lininger, LLC. I further understand that because of the open office environment, some other patients may see my name on the sign-in sheet, and/or overhear my treatment being discussed in front of or nearby another patient. This is acceptable to me and I will not hold Dr. Steve Lininger, LLC or its employees accountable should such instances occur during the course of my treatment.

Patient Signature: ____ Date: ____ / ____ / ______