

Pre-Qualification Form

Please read carefully and initial to the left of each one item:

_____ I understand that neither Dr. Kirk McAnsh, D.C. nor Dr. Geri Williams, D,C. are able to care for individuals who have had any type of **work injury including Worker’s Compensation, auto injury, disability or personal injury claims**. Our center is **not** set up to process or bill these types of claims.

_____ I also understand that if I have chosen to sign up for **Medicare** Insurance that I will be required to pay for all my fees upfront. I understand that Medicare does **not** pay for **wellness** chiropractic care. IF I have a secondary insurance policy, I understand that **I need to contact them to have them set up “CROSS-OVER BILLING” in order for Medicare to forward my claims over my secondary insurance company for possible reimbursement**. If my secondary insurance company does pay, I understand that Maximum Performance Family Wellness Center agrees to reimburse me, minus any co-pays or deductibles.

_____ I understand that IF this is my first Brain STEM Adjustment (or if it has been **more than six months** since my last one) **I understand that I will need up to 10 visits during my first month of care**. On (or about) my 10th visit I understand I will be re-evaluated to see how well I am progressing.

Client Name Printed

Date

Client Signature

Center Representative



www.AlpenaChiropractor.com

(989) 356-WELL (9355)

Reviewed by ____

Maximum Performance Family Wellness Center

Application for Upper Cervical Care Form (Client Fills Out)

Today's Date: _____

Name: _____ **Birth date:** _____

Address: _____ SSN#: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Marital status: _____ Gender: _____ Number of children: _____

Employer: _____ Work phone: _____ Type of work: _____

E-MAIL ADDRESS (will not be given out or sold – for important information and special offers from us only!): _____. Providing the above contact info constitutes permission for us to communicate with you via these means.

What phone number is the best number to call regarding appointments reminders/success information: _____. Can we leave a message at that number you provided?: Y N

Spouses Name: _____ Spouses Birth date: _____

Spouses Employer: _____ Work phone: _____

Type of work: _____

Please describe the reason you are visiting us today: _____

Please list ALL major **FALLS, BUMPS, ACCIDENTS & INJURIES** (with approximate year they occurred): _____

Please list ALL **DRUGS** you are taking: _____

Please list ALL **ALLERGIES:** _____

Please list ALL **SURGERIES** with dates: _____

Reviewed by ____

Maximum Performance Family Wellness Center

Application for Upper Cervical Care Form (Client Fills Out) - Con't.

Please list ALL NUTRITIONAL SUPPLEMENTS (vitamins, minerals, herbs, etc.) that you are currently taking: _____

How do you know you need those particular products and dosages?: _____

Have you ever received any type of nutritional testing before?: Y N

If so, what type?: _____

Is your Blood PRESSURE: Low Normal High

Is your Blood SUGAR: Low Normal High

What is your Blood TYPE: O A B AB (circle one if known)

Are you aware of any difficulties during your childbirth?: _____

For Women Only:

Are you pregnant?: Yes No Do you have **irregular** cycles?: Yes No

Are you nursing?: Yes No Do you have breast implants?: Yes No

Are you taking birth control?: Yes No Do you experience painful periods?: Yes No

Since the time you first noticed your current “challenges” to living a more successful life, **what have you tried to do to rid yourself of them hasn’t worked as well as you had hoped?**

Example: ice, heat, Over-the-Counter medications, prescription drugs, physical therapy, surgery, radiation, etc.:

While those things you listed above **may** have helped a little **temporarily**, **do you see that they haven’t truly gotten rid of your challenges yet?:** _____ Yes _____ No

How does it make you **feel emotionally** to **still** be trying to address your challenges to living a more successful life?: _____

Reviewed by ____

Maximum Performance Family Wellness Center

Application for Upper Cervical Care Form (Client Fills Out) - Con't.

When your challenges are at their worst, specifically, how does it **interfere with your success in your life**? Do you have less energy; get less done; get more irritable; stress and argue more; drink (more) alcohol, smoke (more) cigarettes, eat (more) junk food, take (more) medications, etc.?: _____

How do your challenges affect **your success in school or at your job**?: _____

What **hobbies or interests** do you have outside of work?: _____

When your challenges are at their worst, how do they prevent **your success with your hobby or interests**?: _____

Is there **anything else** you would do more of or just enjoy more if it wasn't for your "success challenges"?: _____

At this point, would you agree that it's time to try a **new approach** to improving your success in life?: _____ Yes _____ No

On a scale of 1 - 10, with 10 being the highest, **how much do you want to improve your overcome your challenge**?: _____

Have you been adjusted by a Doctor of Chiropractic before?: Y N

Reason for those visits: _____

Previous chiropractor: _____ Date of last visit: _____

Did your previous chiropractor recommend a care program to help you live a more successful life year round?: Y N

Do you wear: **heel lifts** or insoles?: Y N **If so, are they the same thickness?**: Y N

Please remember that IF it this is your first Brain STEM Adjustment (or if it has been more than **six months** since your last one), **I understand that I will need 10 visits during my first month of care.** I also understand that I will be re-evaluated to see how well I am progressing and will receive a Progress Report on (or about) my 10th visit.

Are you willing and able to come in for 10 visits (a commitment of 4 hours in our center) within the next month?: _____ Yes _____ No (Remember, physical therapy often requires a commitment of 24- 36 hours in their facility as well as daily exercises at home)!

Reviewed by _____