New Patient Forms

Name_____ Date___/___/___ Age____ Male / Female

Address_____ City_____ State____ ZIP_____

Phone: Home_____ Cell _____ Provider _____

Email Address _____ Date of Birth _____/_____/_____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages & Gender _____

_____

_____

Who may we thank for referring you in? _____ EVAL COST _____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List Worst First	Rate Severity 1= Mild 10=Unbearable	When did this episode start?	Did you have this condition before? when?	Did the problem begin with an injury**?**	Constant or Intermittent?

Since your problem started, is it

___ ABOUT THE SAME ___GETTING BETTER ___GETTING WORSE

What makes it worse? _____

What helps make it better? _____

Have you seen any other doctors for this condition?

_____Chiropractor _____Medical Doctor _____Other

If so, WHO & WHEN _____

List Surgeries and Date_____

_____

List all MEDICATIONS you are currently taking_____

_____

When was your last Auto Accident? _____

Have you had previous chiropractic care? ____YES ____NO If YES, WHEN &

WHO_____

Have you ever been knocked unconscious? ____YES ____NO

Fractured any bones? ____YES ____NO If YES, Please describe _____

Any other bodily trauma? _____

CIRCLE ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

DIZZINESS ☐	ASTHMA ☐	KIDNEY PROBLEMS ☐	CHRONIC FATIGUE ☐
HEADACHES ☐	ULCERS ☐	BLADDER PROBLEMS ☐	LUPUS ☐
VERTIGO ☐	CHEST PAINS ☐	IRRITABLE BLADDER ☐	FYBROMYALGIA ☐
EAR INFECTIONS ☐	ARM NUMBNESS ☐	SCIATICA ☐	ADD / ADHD ☐
GRATING OF NECK ☐	ARM PAIN ☐	LEG NUMBNESS ☐	GERD ☐
TMJ ☐	HAND NUMBNESS ☐	FEET NUMBNESS ☐	NERVOUSNESS ☐
NECK PAIN ☐	SHOULDER PAIN ☐	LOW BACK PAIN ☐	EPILEPSY ☐
MIGRAINES ☐	HEART DISORDERS ☐	HIP PAIN ☐	DISC PROBLEMS ☐
STIFFNESS IN NECK ☐	MID BACK PAIN ☐	LEG PAINS ☐	INFERTILITY ☐
CHRONIC SINUS ☐	STOMACH DISORDERS ☐	KNEE PAIN ☐	
THROAT ISSUES ☐	NAUSEA ☐	LIVER DISEASE ☐	OTHER_____
THYROID ISSUES ☐	REFLUX ☐	MENSTRUAL ISSUES ☐	_____
ANXIETY ☐	DEPRESSION ☐	ADDICTION ☐	

CHECK ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE ☐ - CANCER ☐ - HEART DISEASE ☐ - SPINAL SURGERY ☐ - SEIZURES ☐ - SPINAL FRACTURE ☐ - SCOLIOSIS ☐ – DIABETES ☐

Consent to Initiate Care

At our office, we have one simple goal. We want to change your life by rendering the highest quality Chiropractic care. We do this by specific scientific chiropractic adjustments designed to remove vertebral subluxations affecting your nervous system and interfering with your inborn given innate ability to be healthy. To accomplish this goal, we must work together. We believe good Chiropractic care requires a partnership between you and us. Please read over our clinic's procedures to understand how our clinic functions, so that you can be an active participant in your care. If you have any questions please feel free to ask us.

To initiate care at our facility, there are **two required visits** you will be scheduled for, other than this visit, your Initial Examination visit. If you cannot attend either of these two subsequent visits, the negative impact on your care will be profound, and we cannot in good conscious initiate your care. These required visits are:

1. **Your Brief Report of Findings:** This visit is your first visit after your examination. This is where the doctor tells you if he feels chiropractic can help you and briefly explains your care. In most instances you will receive your fist adjustment on this visit, unless you would prefer to receive care at that time or to wait until after your X-ray Report.
2. **Doctor's Report:** This will be your longest visit at our clinic and will consist of a detailed report of findings with recommendations for your care. Also included will be recommendations on what to do between visits and a detailed explanation of your care plan. Any x-rays taken will be reviewed at this time. *We highly recommend that spouses and adult family members attend this visit with the patient*. Due to the time required, there are only certain times this visit is given. Check with our receptionist or the doctor for available times. Total visit time about 50 - 70 minutes.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc, and although rare, minor fractures have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures, provided ave been explained to me to my satisfaction and I have conveyed my understanding of both 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.

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996. (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operation. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Print your name _____ **Today's date** _____

Sign your name _____