

New Patient Forms

*** Please notify receptionist if your conditions are due to an auto or work related accident

Last Name _____ First _____ Middle In. _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
 E-mail _____ Spouse's Name _____
 Occupation _____ Employer _____ Hours per week worked _____
 Social Security # _____ Age _____ D.O.B. ____/____/____ Male Female Married Single
 Emergency Contact _____ Ph.# _____ Relationship: _____
 Family Doctor _____ Phone # _____ Last Exam Date _____
 Previous Chiropractic Care (doctor, date last seen, results) _____
 Name/Age of your Children _____
 If you were referred to our office, whom may we thank? _____

Primary Health Complaint(s) _____

Other doctors seen for this condition: Yes No Who and Where? _____

Type of Treatment(s) _____ Results _____

For this condition have you had: X-Rays MRI CT Blood Work Other _____

Describe the Pain (mark all that apply) Dull Sharp Ache Throb Burning Numb Tingling Cramping Spasm Shooting

Does the pain move into other body parts: Head Neck Shoulder Arm/Hand Hip/Buttocks Leg/Foot _____

Circle the INTENSITY of your PAIN when present (0=no pain, 10=severe pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mark the FREQUENCY of your PAIN: Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)

In the Past 6 Months: Check <u>ONLY</u> one box per Symptom. <u>C</u> = Constant, <u>F</u> = Frequent (weekly), <u>O</u> = Occasional (Monthly), <u>R</u> = Right, <u>L</u> = Left			
C F O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck Pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arm Pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arm Numbness (R - L)	C F O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand Pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand Numbness (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain	C F O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Buttock Pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip Joint Pain (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain down leg (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Leg numbness (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot Pain (R - L)	C F O <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot numbness (R - L) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of Balance/Dizzy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____

*<u>WOMEN</u> <u>ONLY</u>:	I have been advised that x-rays could be hazardous to an unborn child and if I have any concerns it is my responsibility to ask the doctors. [MARK ONLY ONE] <input type="checkbox"/> I am <u>NOT</u> PREGNANT <u>OR</u> <input type="checkbox"/> I am pregnant or could be pregnant.
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HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office from all liability and give permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

Consent to Receive Chiropractic Care
 I, the undersigned, give this office and its doctor(s) permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis, and treatment. Chiropractic care seldom causes complications, but in rare cases, due to underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. The doctor(s) will not provide care, without consent of the patient, if they are aware of any contraindication that may be present. It is the responsibility of the patient to discuss with the doctor(s) any known underlying deformities or defects that may not otherwise come to the attention of the doctor. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known, is in my best interests.

I have read and fully understand the above statements and accept chiropractic care on this basis.

Name _____ Signature _____ Date _____