New Patient Form

Welcome!

Last___________________________ **First**_______________________ **Middle Initial**_____ **DOB**_______________

Address____________________________________ **City**________________________ **ST**_____ **ZIP**______________

Phone (H)_______________________**(C)**_______________________ **Email**__________________________________

Occupation______________________________ **Employer**____

Relationship Status S M W D **Spouse's Name**__________________________ **DOB**________________

Children's Names and Ages____

Have you had previous Chiropractic care? Yes No **Positive Experience?** Yes No

Who referred you?________________________ Walk in Google MD Referral Other__________________

Who is your primary care physician?______________________________ **Phone**______________________

Date of last physical/Exam _____________________ **May we update your medical doctor regarding your treatment in our office?** Yes No

Have you ever been in an auto accident? Past Year Past 5 Years Over 5 years Never

Please Describe____

Please list All surgeries, injuries, accidents, falls etc.: ____

____

Occupation Information:

Job Involves: Sitting Standing**: How long?**___________ Lifting: **How much?**_________ Bending Twisting Turning Stopping

Physical Activity at work: Sedentary Light Labor Manual Labor Intense Labor

Have you missed any time from work due to injury: Yes **How long?**____________________ No

Do any of your work activities aggravate your main complaints? Yes No **If yes please explain:**

____

Please list any medications or vitamins you are currently taking.

_____________________________________ **What is this for?**____

_____________________________________ **What is this for?**____

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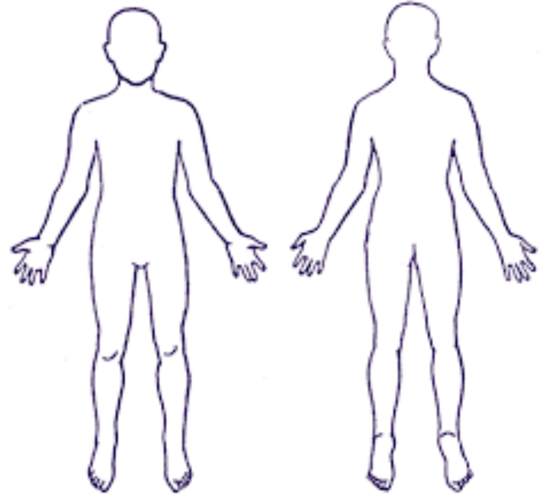
_____________________________________ **What is this for?**____

Current Complaints- List current symptoms separately in order of severity

1st Body Part______________________________________

Please mark areas of pain on figures below



Date symptom first appeared:_______________________

How often do you experience these symptoms?

Constant Frequent Intermittent Occasional Rare

What makes the symptom increase?________________

What makes the symptom Decrease?_______________

Type of Pain? Sharp Dull Aching Burn Throb Numb Other__

Please Rate the Intensity of your symptoms.

No Pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 **Extreme**

Does Pain Radiate? Yes No **If yes, where?**__________

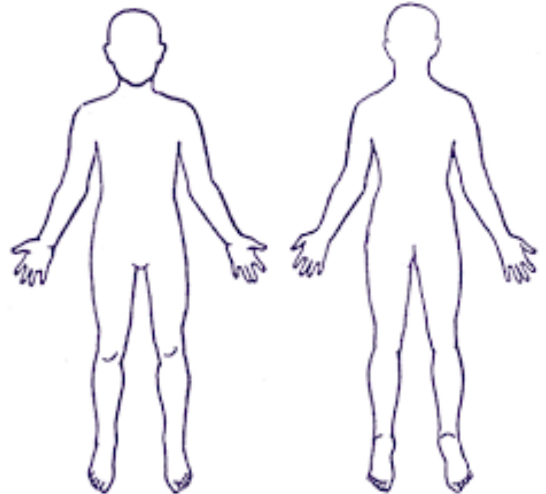
Has Pain Affected work? Missed work Reduced work

Does Pain Affect Appetite? Yes No **Does weather affect pain?** Yes No

Have you Received Treatment? Yes No **X rays?** Yes No

2st Body Part______________________________________

Please mark areas of pain on figures below



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Has Pain Affected work? Missed work Reduced work

Does Pain Affect Appetite? Yes No **Does weather affect pain?** Yes No

Have you Received Treatment? Yes No **X rays?** Yes No

Please list any other concerns in order of severity

1)____

2)____

3)____

4)____

Do you Smoke? Yes No If yes, how many packs per week?_____ **Have you ever smoked in the Past**? Yes No When did you quit?____________ **Do you consume other kinds of Tabaco?** Yes No

Do you consume Alcohol? Yes No If yes, How many drinks per week? ______________________________

Do you consume Caffeine? Yes No If yes, How many drinks per day? ______________________________

Do you consume Soft Drinks? Yes No If yes, How many drinks per day? ___________________________

Do you consume Water? Yes No If yes, How many ounces per day? ________________________________

Do you consume Processed food? Yes No If yes, How many meals per week? _____________________

Do you consume Homemade Foods? Yes No If yes, How many times per week? __________________

Do you consume Drugs? Yes No If yes, How many times per week and kind? ______________________

Do you consume OTC Stimulants? Yes No If yes, How many times per week? ____________________

Do you exercise? Yes No If yes, How many times per week and what type? _________________________

Do you have a high stress level? Yes No If yes, list reasons ____

For Females only

Are you pregnant? Yes No **Date of last Menstrual Cycle**____________________

Are you nursing? Yes No **Do you take HRT?** Yes No **Date of last Mammogram**______________

Do you have painful periods? Yes No **Date of last PAP/ Pelvic exam**____________________________

Do you have breast implants? Yes No **Do you have irregular cycles?** Yes No

Are you taking birth control? Yes no **if yes, what kind?**____

Health History

HIV/AIDS	Allergy Shots	Anemia	Anxiety	Anorexia	Appendicitis	Arthritis
Asthma	Bleeding	Breast Lump	Bronchitis	Bulimia	Cancer	Cataracts
Chicken Pox	Depression	Diabetes	Emphysema	Epilepsy	Fractures	Glaucoma
Goiter	Gonorrhea	Gout	Heart Dx	Hepatitis	Hernia	Fibromyalgia
Herpes	STD	Kidney Dx	Liver Dx	Measles	Migraines	Miscarriage
Mono	M.S.	Mumps	Osteoporosis	Parkinson's	Polio	Pacemaker
Pneumonia	Prostate	Prosthesis	Implants	Rheumatoid	Stroke	Thyroid
Tonsillitis	Tuberculosis	Tumors	Typhoid	Ulcers	Whooping cough	

Chronic Fatigue High Blood Pressure Herniated Disc High Cholesterol

Other____

Family History- list any diseases and conditions that are current health problems of family members

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CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including varies modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below. I understand that results are not guaranteed. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to fractures, disc injuries, strokes dislocations and sprains. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, is in my best interests. I further understand there are treatment options available for my condition other than chiropractic procedures. These treatment options include but not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and I have read or have had read to me the above content. I have also had an opportunity to ask questions about its content, and my signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Initial_______________

PATIENT ACKNOWLEDGEMENT, HIPAA AND CONSENT FOR USE OF HEALTH CARE INFORMATION

The undersigned does hereby acknowledge that he or she has been offered a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner of consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. The undersign may revoke this Consent in writing at any time and all future disclosures will then cease.

Initial_______________

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand my insurance benefits are my responsibility; I will contact my insurance company with questions regarding my coverage. I will provide proof of insurance and complete all patient information prior to seeing the doctor. Furthermore, I understand that Sands Chiropractic & Performance Center will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to Sands Chiropractic & Performance Center. I understand al co-payments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on Sands Chiropractic & Performance Center to collect co-payments and deductibles from me is considered fraud. I will help in the upholding of the law by paying my co-payment at each visit. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I understand I am responsible for informing Sands Chiropractic & Performance of any changes to my insurance plan. If my insurance company does not pay my claim within 90 days I understand Sands Chiropractic & Performance Center will bill my statement to me. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered will be immediately due and payable. If I miss more than two

appointments, without canceling more than 24 hours in advance, I understand there will be a $25.00 cancelation policy. Sands Chiropractic & Performance Center will bill the charges directly to me.

Initial_______________

I understand the information contained within this form and guarantee this form was completed to the best of my knowledge.

Signature:____ Date_________________________

Guardian's Signature:____ Date_________________________