New Patient Form
Welcome!

Last_____First_____Middle Initial_____DOB_____

Address_____City_____State_____Zip_____

Phone (H)_____(Cell)_____Email_____

Occupation_____ Employer_____

Relationship Status S M W D Spouse's Name_____DOB_____

Children's Names & Ages_____

Have you seen a chiropractor before? Yes/No Name of Dr_____ Positive Experience? Yes/No

How did you hear about us? ___Walk-In ___Google ___Website ___Social Media ___Referral Other_____

Who can we thank for referring you? _____

Name of your primary care physician_____ 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? (Circle) Past Year Past 5 Years Over 5 Years Never

Please describe_____

Please list all surgeries, injuries, accidents, falls, etc_____

_____

Occupations Information

Job involves (Circle):

Sitting Twisting Turning Stopping Bending Standing: How long? _____ Lifting: How much? _____

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

Have you missed any time from work due to injury? (Circle) Yes / No If Yes, how long?_____

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?_____

_____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 Rarely

What makes the symptom increase? _____

What makes the symptom decrease? _____

Type of Pain? Sharp Dull Aching Burn Throb Numb Other_____

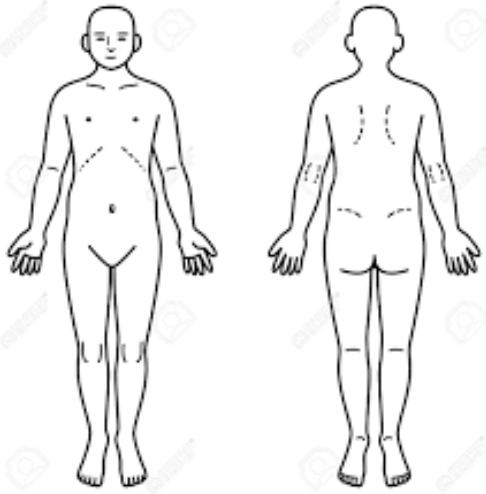
Please rate the intensity of your symptoms:

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

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 If Yes **From whom? _____** **X-Rays?** Yes / No

In the past 24-hours, has this condition been: Better Worse Same

If worse, please explain: _____

2nd 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 Rarely

What makes the symptom increase? _____

What makes the symptom decrease? _____

Type of Pain? Sharp Dull Aching Burn Throb Numb Other_____

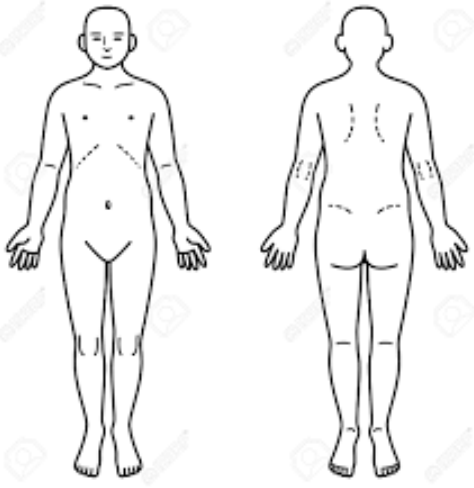
Please rate the intensity of your symptoms

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

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 If Yes, **From whom? _____** **X-Rays?** Yes / No

In the past 24-hours, has this condition been: Better Worse Same

If worse, please explain: _____

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 cups per day? _____

Do you consume Soft Drinks? Yes / No If yes, how many drinks per week?_____

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 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 type?_____

Do you have a high stress level? Yes / No If yes, list reasons_____

For Females Only

Are you pregnant? Yes / No Are you nursing? Yes / No Do you have breast implants? Yes / No

Health History (Circle All Applicable)

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

Other:_____

Family History

List any diseases or conditions that are current health problems of family members: _____

_____

_____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient names below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors or 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 judgement during the course of the procedure, which the doctor feels at the time, is in my best interests. I understand that any x-rays or other diagnosis completed is related to chiropractic only and is not for the identification of other diseases that may be present. Chiropractic is not a substitute for my general practitioner.

I further understand there are treatment options including 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 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 this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

_____Initial

PATIENT ACKNOWLEDEMENT, 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 offices' 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 undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law. The undersigned may revoke this consent in writing at any time and all future disclosures will cease.

_____Initial

PAYMENT

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 ProActive Chiropractic Care 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 ProActive Chiropractic Care.

I understand all copayments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on ProActive Chiropractic Care to collect copayments and deductibles from me is considered fraud. I will help in the upholding of the law by paying my copayment at each visit. I will also

authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payers 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 ProActive Chiropractic Care of any changes to my insurance plan. If my insurance company does not pay my claim within 90 days, I understand ProActive Chiropractic Care 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 chiropractic appointments without cancelling more than 24-hours in advance, I understand there will be a $25 cancellation fee. ProActive Chiropractic Care will bill the charges directly to me. If I miss a massage appointment without cancelling more than 24-hours in advance, I understand there will be a $20 charge for a 30-minute massage and $30 for a 60-minute massage.

_____Initial

I have read the explanation of the above chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**
_____	_____	_____
Guardian's Printed Name	**Signature**	**Date**

(If patient is under 18)