SPINAL HEALTH & WELLNESS

NEW PATIENT APPLICATION

Our mission is to support each person in achieving optimum health through quality care and education, so that he may understand health and Chiropractic and, in turn, educate others.

Outline of Procedures for Prospective New Patients:

Step 1: Please complete a personal health history questionnaire. All information is confidential.

Step 2: At your first consultation, you and the Doctor will discuss your health problems to determine if Chiropractic Care is appropriate for your health problem.

Step 3: You will be advised regarding the need for additional procedures such as x-rays or laboratory tests, if necessary. If your case requires immediate attention, care will be administered.

Step 4: You will be advised when to return for a "Report of Findings" consultation when your Doctor will inform you of the examination results, and whether your case has been accepted. Insurance and financial agreements will be discussed. A treatment program will be recommended based on your needs.

Step 5: Treatment will begin and your case will be monitored with re-exams and re-x-rays, as needed, until your condition has been fully corrected or until maximum improvement has been obtained.

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI:_____

DOB:_____ Age:_____ Gender: **M** **F** SSN: _____

Weight:_____ Height:_____ Check One: □ Married/Partner □ Single □ Widowed □ Divorced □ Separated

Address: _____City: _____State: _____ Zip: _____

Home Phone: _____ Business Phone:_____ Cell Phone: _____

Email:_____ Business/Employer_____

Emergency Contact:

Name:_____Relationship:_____Phone:_____

Party responsible for your bill: □ Self □ Spouse □ Parent □ Other_____

How did you hear about our office?

Referred to this office by:_____

CURRENT HEALTH CONCERNS

Chief health concern: _____

Location of problem:_____

What caused this problem? _____

What makes it feel better?_____

What aggravates this condition?_____

How would you describe how it feels?_____

On a scale of 0 to 10 where 0 is normal function and no complaint and 10 is the worst it could be, what number would you assign to your condition? (Please circle) 0 1 2 3 4 5 6 7 8 9 10

How often does this problem bother you?_____

How long have you had this problem?_____

What bothers you the most about having this problem?_____

Previous doctors seen for this problem (please give name, address, phone number, if able): _____

_____

Please describe any significant past trauma/major accidents or falls?_____

_____

Other health concerns / pertinent information?_____

_____

Please check or describe:

Does anyone else in your family have the same or similar condition? If yes, who?

Major surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall bladder ☐ Hernia
☐ Broken bones: _____ ☐ Other: _____

HEALTH CONDITIONS

How would you rate your overall health? □ Poor □ Fair □ Good □ Very good □ Excellent

What kind of regular exercise do you perform? □ None □ Light □ Moderate □ Strenuous

List your favorite hobbies/sports/activities:_____

Family Health History:

Are there any serious medical conditions (such as arthritis, cancer, heart problems, diabetes, or lupus) in your immediate family?

Father _____Mother _____

Brothers / Sisters _____

(if yes, please explain)?

_____

_____

Do you currently take: □ Nerve Pills □ Pain killers/Muscle Relaxants □ Insulin □ Blood Pressure Medicine
Please list any prescription or over-the-counter medications or recreational drugs:_____

_____

Vitamins/Supplements/Other:_____

Primary Care Doctor Information:

Name:_____Contact Information:_____

Approximate date of last visit:_____

Additional Notes/Comments:

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

☐ Appendicitis	☐ Malaria	☐ Chicken Pox	☐ Alcoholism	☐ HIV
☐ Scarlet Fever	☐ Tuberculosis	☐ Diabetes	☐ Venereal Infection	☐ Leprosy
☐ Diptheria	☐ Whooping Cough	☐ Cancer	☐ Arthritis	
☐ Typhoid Fever	☐ Anemia	☐ Heart Disease	☐ Epilepsy	
☐ Pneumonia	☐ Measles	☐ Goiter	☐ Mental Disorder	
☐ Rheumatic Fever	☐ Mumps	☐ Influenza	☐ Lumbago	
☐ Polio	☐ Small Pox	☐ Pleurisy	☐ Eczema	

CHECK ANY OF THE FOLLOWING YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

☐ Low Back Pain
☐ Pain between Shoulders
☐ Neck pain
☐ Arm pain
☐ Joint pain/stiffness
☐ Walking problems
☐ Difficulty chewing/clicking jaw

NERVOUS SYSTEM CODE

☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities

GENERAL CODE

☐ Allergies
☐ Loss of Sleep
☐ Fever

GENITO-URINARY CODE

☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

EENT CODE

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

GASTRO-INTESTINAL CODE

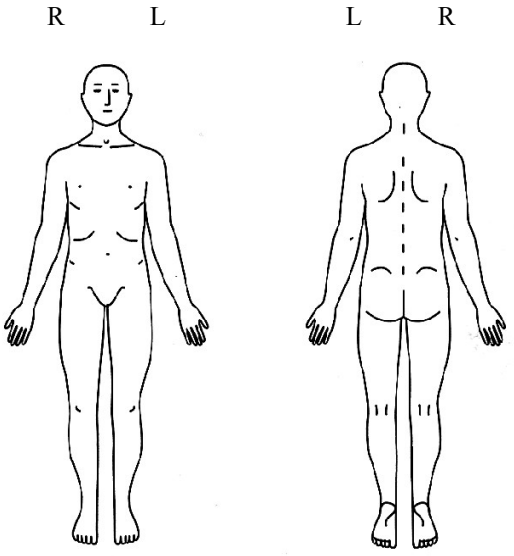
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Trouble
☐ Gall Bladder problems
☐ Weight trouble
☐ Abdominal cramps
☐ Gas/Bloating after meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

C-V-R CODE

☐ Chest pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular heartbeat
☐ Heart problems
☐ Lung problems/Congestion
☐ Varicose veins
☐ Ankle Swelling

MALE/FEMALE CODE

☐ Menstrual Irrgularity
☐ Menstrual Cramping
☐ Vagina Pain/Infections
☐ Breast Pain/Lumps
☐ Menstrual Irrgularity
☐ Prostate/Sexual Dysfunction
☐ Genital Herpes
☐ Are you pregnant? ☐ NO ☐ YES
☐ Not Sure



Please shade in the diagram the area of your discomfort.

PERSONAL HISTORY

Vaccinations & Injections:

☐ Smallpox ☐ Polio ☐ D.P.T. ☐ Tetanus – date _____ ☐ Flu ☐ Measles

☐ Hepatitis ☐ Spinal Tap ☐ Other _____

Radiology:

☐ Previous X-Rays _____ ☐ CT Scans _____ ☐ MRI _____

Habits:

☐ Sleep (hours/night) _____ ☐ Coffee/Tea (cups/day) _____

☐ Alcohol (drinks/week) _____ ☐ Tobacco (packs/day) _____ ☐ Chew _____

☐ Social Drugs _____ ☐ Exercise _____ ☐ Hobbies _____

Why chiropractic? People go to Doctors of Chiropractic for a variety of reasons. Some go for symptomatic relief of pain (Relief Care). Others are interested in having the cause of their problem as well as the symptoms corrected (Corrective Care). Still, others want whatever is malfunctioning in their bodies brought to the highest state of health possible (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care you desire so that we may be guided by your wishes whenever possible.

☐ **Relief Care** ☐ **Corrective Care** ☐ **Comprehensive Care**
☐ **Check here if you want the Doctor to select the appropriate care for your condition.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. Furthermore, I understand that this Health Care Office will prepare any necessary forms to assist me in making collection. Furthermore, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be due immediately and payable. I hereby authorize the Doctor to treat my condition as she deems necessary through the use of chiropractic adjustments. It is understood and agreed that the amount paid to this office for x-rays is for interpretation, and the radiographs will remain the property of the Health Care Office.

I also authorize Spinal Health & Wellness to release any information related to my case as deemed necessary.

Patient's Signature _____ Date _____

Guardian (when applicable) _____

DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: *You Have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.*

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, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other license Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a back-up for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. 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, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. 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.

To be completed by the patient:

_____
Printed Name

_____
Signature of Patient

_____
Date Signed

To be completed by the patient's representative, if necessary, e.g. if the patient is a minor or physically or legally incapacitated.

_____
Printed Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

as:

_____
Relationship or Authority of Patient's Representative

_____
Date Signed

To be completed by doctor or staff

_____
Witness to Patient's Signature

_____
Date

_____
Translated by

_____
Date