New Practice Member Information

Congratulations on your first step towards a more abundant life!

Name_______________________________________ Marital Status: M W D S Date_______________
Address _____________________________City_____________________ State__________ Zip____________
Birth Date____________________ # of Children: ___________ Spouses Name_____________________
Employer__________________ Occupation___________________ Work #_________________________
Cell #___________________Home #____________________ Email ____________________________
What kind of reminder would you like for your next visit? (Circle one) Text Phone Msg
How did you discover our office? ____

Reason for consulting our office today: ____
Current health concerns: Date it began Why it began Severity 1-10, 10 is worst
1. ___________________________ ____________ ____
2. ___________________________ ____________ ____
3.___________________________ ____________ ____
Are you unable to do things that you would normally do because of these concerns?_____________________
Have you seen any other professional for these health concerns? Y N
If yes, describe treatment given and the results____

Please check each of the following that have ever applied to you:

☐ Spinal/Cranial X-rays, CT, MRI, PET Scan	☐ Car accident
☐ Personal or family history of hypertension	☐ Whiplash Injury
☐ Personal or family history of stroke	☐ Spinal injury
☐ Arthritis (OA, RA, Psoriatic, AS, Reiter's)	☐ Head injury
☐ Headaches	☐ Falls
☐ Osteoporosis	☐ Neurological conditions
☐ Cancer	☐ Physical restrictions
☐ Blood in urine	☐ Spinal conditions (Scoliosis, etc)
☐ Unexplainable night pains	☐ Ligamentous laxity (Collagen disorders)
☐ Weight loss of an unknown reason	☐ Marfan's, Ehlers-Danlos Syndromes
☐ Cigarette use	☐ Surgery
☐ Sciatica	☐ Corticosteroid use
☐ Previous or current bone fracture	☐ Birth control pills or patch

If you checked any of the above boxes please explain in detail when and how the incident occurred as well as what was done about it and how it currently affects you.

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____
____

Do you have any conditions that may alter the way in which your care is delivered?
____

Do you have any other health conditions that we should be aware of?
____

Are you currently taking any pain medications? If so, which? _____________________________________

Have you ever been to a Chiropractor before? Y N When____________________
Why did you go?____
What were the results?____
Why did you stop going?____
Does it bother you to have your neck or back adjusted by hand (where there is a "pop" or "crack") Y N

Is there anything else that we need to know about you that were not addressed on this form?
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Payment Policy

Payment is due at the time of service. We accept cash, check, credit cards, HSA, and FSA. If you have insurance you may be able to be reimbursed for part of your expenses at our office, please ask for a receipt to submit to your insurance company.

Please circle one of each of the following:

I am I am NOT interested in information about insurance reimbursement.
I have DO NOT have Medicare (Muscle Activation and NAET are NOT covered by Medicare.)

Missed appointments that are not cancelled or rescheduled within 24 hours of the prescheduled time **are subject to a $20 fee for each 10 minute time period missed.**

Informed Consent

Your examination will determine how your neuro-musculo-skeletal system is functioning. Treatment is aimed at restoring proper function to dysfunctional areas. By restoring proper function the body is more likely to heal itself, however exactly what benefits you will receive no one can predict. There are certain risks that have been reported to be associated with chiropractic care. Such risks include, but are not limited to fractures, dislocation, bruising, stroke, Horner's syndrome and other neurological complications. However, these incidents are extremely rare, and the doctor will use his best judgment to try to avoid any negative events. THE MOST COMMON ADVERSE EFFECT THAT YOU MIGHT EXPERIENCE IS MUSCLE SORENESS AND/OR BRUISING. By my signature I acknowledge that there are risks inherent in receiving chiropractic care and I give the doctor permission to perform an examination and deliver treatment to me. I also acknowledge that the information I have provided is complete and accurate to the best of my ability.

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Name Signature Date

Privacy Notice

Your health information is private and protected by law. Your information will only be used or disclosed for the purpose of giving care, billing, or supporting day-to-day operations. You have the right to review your file. You may restrict all or part of your health information from being released. Our privacy manual is available at any time for you to review. A more detailed privacy policy is available that you may take with you upon request.

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Name Signature Date

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Witness Signature Date