New Patient Health History Form

Redlands CHIROPRACTIC

Date:

PATIENT DATA

First Name		**Last Name**			
Date of Birth		**Age**		**Occupation**	
Email Address *				**Employer**	

** Your email will not be shared with any third parties*

How did you hear about our office?		**Referred to a specific doctor?**	

ADDITIONAL INFORMATION

Address		**City**		**State**		**Zip**	
Telephone		**Cell Phone**		**SSN**			
Height		**Weight**		**Gender**			
Marital Status		**Spouse's Name**					

Spouse's Employer: Spouse's Occupation:

Emergency Contact		**Phone**	

REASON FOR YOUR VISIT

CURRENT COMPLAINTS

Nature of Injury	☐ **Auto** ☐ **Work** ☐ **Other**	**Date of Injury**	
		Date Symptoms Appeared	
Please Describe			
Same condition in past?	☐ No ☐ Yes	**If yes, when?**	
Other Practitioners Seen*			

* for the current condition

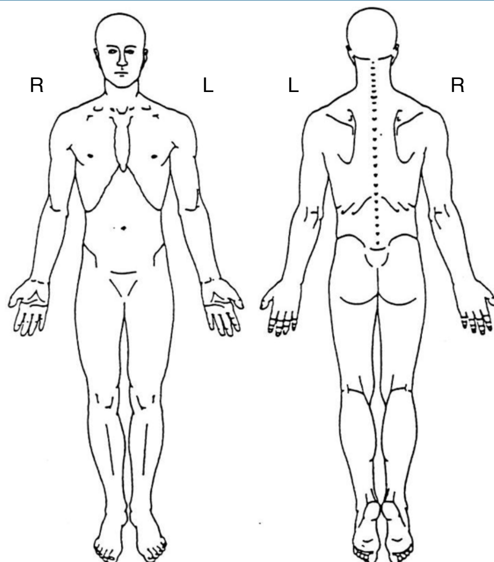
Prior Chiropractic Care	☐ No ☐ Yes*	***Please Describe**	

CURRENT COMPLAINTS

DIAGRAMS

Please use the following to indicate **TYPE**, **LOCATION** and **SEVERITY** of the symptoms you are currently experiencing.

PAIN DIAGRAM KEY	
A	*Ache*
B	*Burning*
N	*Numbness*
O	*Other*
P	*Pins & Needles*
S	*Stabbing*



VISUAL ANALOG PAIN SCALE	
0	*No Pain*
1	*Minimal Pain (annoyance)*
2	*Constant Minimal to Intermittent Slight Pain*
3	*Constant Slight Pain (Some Handicap)*
4	*Constant Slight to Intermittent Moderate Pain*
5	*Contant Slight to Frequent Moderate Pain*
6	*Intermittent Moderate Pain (Marked Handicap)*
7	*Frequent Moderate Pain*
8	*Constant Moderate Pain*
9	*Constant Moderate to Intermittent Severe Pain*
10	*Constant Severe Pain (Incapacitated)*

Date: ____________________

CURRENT COMPLAINT (CONTINUED)

Question			Question		
Do you experience pain every day?	☐ Yes	☐ No	**Do your symptoms interfere with daily life?**	☐ Yes	☐ No
Does pain wake you up at night?	☐ Yes	☐ No	**Symptoms worse at certain times of day?**	☐ Yes	☐ No
Do changes in weather affect symptoms?	☐ Yes	☐ No	**Do you wear orthotics?**	☐ Yes	☐ No

What activities aggravate your symptoms?

MEDICAL HISTORY

PAST MEDICAL HISTORY

Had treatment for any conditions this year?* ☐ Yes ☐ No * If yes, describe below

*** Please Describe**

Date of Last Physical Exam | **Is there a chance that you are Pregnant?** ☐ Yes ☐ No

Have you had x-rays or any imaging done? ☐ Yes ☐ No | **If yes, where?**

What medications are you taking? For what?

What vitamins, minerals, herbs do you take?

HAVE YOU EVER:

Broken Bones?	☐ No	☐ Yes*	* explain below
Been Hospitalized?	☐ No	☐ Yes*	* explain below
Been in Auto Accident?	☐ No	☐ Yes*	* explain below
Had Sprains/Strains?	☐ No	☐ Yes*	* explain below
Been Struck Unconcious?	☐ No	☐ Yes*	* explain below
Had Surgery?	☐ No	☐ Yes*	* explain below
History of Stroke or TIA?	☐ No	☐ Yes*	* explain below

* DESCRIBE ANY YES ANSWERS:

HABITS

Alcohol	☐ None	☐ Light	☐ Moderate	☐ Heavy
Tobacco	☐ None	☐ Light	☐ Moderate	☐ Heavy
Exercise	☐ None	☐ Light	☐ Moderate	☐ Heavy
Drugs	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sleep	☐ None	☐ Light	☐ Moderate	☐ Heavy
Appetite	☐ None	☐ Light	☐ Moderate	☐ Heavy
Soft Drinks	☐ None	☐ Light	☐ Moderate	☐ Heavy
Water	☐ None	☐ Light	☐ Moderate	☐ Heavy
Salty Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sugary Foods	☐ None	☐ Light	☐ Moderate	☐ Heavy
Artificial Sweeteners	☐ None	☐ Light	☐ Moderate	☐ Heavy

REVIEW OF SYSTEMS

Have you ever suffered from:

☐ Cancer	☐ Upper Extremity Pain	☐ Loss of Balance	☐ Poor Appetite	☐ Asthma
☐ Seizures	☐ Lower Extremity Pain	☐ Alcoholism	☐ Liver Disease / Hepatitis	☐ Coughing Up Blood
☐ Headache / Migraine	☐ Spinal Curvatre	☐ Depression	☐ Polyps / Diverticulosis	☐ COPD
☐ Diabetes	☐ Arthritis	☐ Anemia	☐ Chest Pain	☐ Blurry / Double Vision
☐ Pacemaker	☐ Poor Posture	☐ Thyroid Disorders	☐ Palpitations	☐ Sinus Problems
☐ High Blood Pressure	☐ Sciatica	☐ Anxiety	☐ Swelling of Ankles	☐ Ear Problems / Ringing
☐ Heart Attack	☐ Fainting	☐ Digestive Problems	☐ Shortness of Breath	☐ Nosebleed
☐ Stroke / TIA	☐ Dis-Coordination	☐ Heartburn	☐ Arteriosclerosis	☐ Difficulty Swallowing
☐ Immune Disorders	☐ Dizziness / Lightheaded	☐ Nausea	☐ Irregular Heart Beat	☐ Menstrual Issues / Irregularity
☐ Neck Pain or Stiffness	☐ Memory Loss	☐ Blood / Mucous in Stool	☐ Arterial Aneurysm	☐ Difficult / Excessive Urination
☐ Mid-Back Pain	☐ Speech Difficulty	☐ Constipation / Diarrhea	☐ Varicose Veins	☐ Kidney Stones
☐ Low Back Pain	☐ Tremor of Limbs	☐ Recent Weight Loss / Gain	☐ Heart Disease / Failure	☐ Other:

FAMILY HISTORY

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Name: ______________________

Date: ______________________

INSURANCE INFORMATION			
Name of Party responsible for payment		**Phone Number**	
Do you have health insurance?	☐ Yes ☐ No	**Name of Insurance Company**	

SIGNATURES			
Name of Insured			
	I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care / treatment, any fees or professional services rendered to me will be immediately due and payable.		
Patient / Guardian Signature		**Date**	

INFORMED CONSENT

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or the patient names below, for whom I am legally responsible) by any licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the chiropractic group listed above. I have had an opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I 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. 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 at the time, based upon the facts then known, is in my best interest. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by 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.

RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement this clinic may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the clinic's charge including but not limited to insurance companies, health care service plans, or worker's compensation carriers.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the clinic any insurance benefits otherwise payable to or on behalf of the undersigned for treatment at the rate not to exceed the clinic's regular charges. It is agreed that payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is responsible for any charges not covered by this assignment.

FINANCIAL AGREEMENT

The undersigned agrees that in consideration of the services to be rendered to the patient he/she herby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to any attorney or collections service for collection, the undersigned shall pay actual attorney's fee and/or collection expense. All delinquent accounts shall bear interest at the legal rate.

I have read, understand, and agree with the terms as described above.

Patient or legal guardian signature		**Date**	

HIPAA NOTICE OF PRIVACY PRACTICES

SEE OFFICE FORM HIPAA-001

I have been provided with, read, and understand the *HIPAA Notice of Privacy Practices*. An original copy of this form is kept in the office as form HIPAA-001.

Patient or legal guardian signature		**Date**	

Name: ______________________________

Date: ______________________________