SPINE AND SPORT FAMILY CHIROPRACTIC
NEW PATIENT PAPERWORK

Date: ___________

Name: ____________________________________ DOB: ___________
Address: __________________________________ City: ___________ State: _________ Zip: _________

How did you hear about our office? ________________________________

Email Address: ____
Primary Telephone: __________________________ Cell: Y or N
Secondary Telephone: ________________________
How would you like to receive reminders? Circle One: Text Voicemail Email Decline All
Ethnicity: ____________Social Security Number: ______________________
Occupation: ________________________________ Title: ____________
Marital Status: M S W D Spouse Name: ____________________ Phone: ________________
Emergency Contact: _______________ Phone: ________________
Do you have children?: Y or N
Names & ages of children:
________________________ ___________________ ________________________

Family Medical Doctor: ___________________________
When doctors work together it benefits you as the patient. Do we have your permission to update your medical doctor regarding your care in this office? Y or N

HISTORY OF PRESENT AND PAST ILLNESS

Please list your top three complaints for coming in today:
1. ____
2. ____
3. ____

Date the symptoms appeared: ______________________
Is this due to Auto______ Work Related_______ Other_________
Have you ever experienced the same or similar condition prior to today's date?:______________________
Days lost from work: ____________________ Date of last physical exam: _________________

In the last 12 months have you had any major illnesses, injuries, falls, auto accidents or surgeries? (Women, please include information about childbirth and dates if possible) Y or N
____

Have you been treated by a physician for any health condition in the last year?
____

Do you have any allergies? Season, food related or otherwise:

____

Please list any medications you are currently taking:

____

Do you currently have a Congenital Condition? Y or N

____

Women:
What was the date of your last menstrual cycle? __________
Is there any possibility of you being pregnant? Y or N

Current/Previous Conditions

Check all that apply

___ Headaches	___ Neck pain	___ Stiff neck	___ Back pain
___ Swelling	___ Broken bones	___ Joint pain	___ Shoulder pain
___ Arm pain	___ Osteoarthritis	___ Seizures	___ Epilepsy
___ HIV Positive	___ Loss of balance/Dizzy	___ Fainting	___ Loss of smell
___ Loss of taste	___ Gallbladder issues	___ Persistent cold feet/hands	___ Arthritis
___ Muscle spasms	___ Frequent colds	___ Indigestion	___ Sinus problems
___ Menstrual pains	___ High blood pressure	___ Fatigue	___ Chest pains/tightness
___ Pacemaker	___ Heart disease	___ Low blood pressure	___ Cancer _____________
___ Rheumatoid Arthritis	___ Circulation Problems	___ Weight Loss/Gain	___ Stroke (date:________)
___ Memory issues	___ Numbness	___ Osteoporosis	___ Other_______________

Social History

Please check next to which events best describe your current lifestyle

OFTEN = "O" SOMETIMES = "S" NEVER = "N"

___ Vigorous Exercise	___ Moderate Exercise	___ No Exercise
___ Alcohol Use	___ Drug Use	___ Caffeine
___ Family Pressures	___ Financial Pressures	___ Other Stress
___ Tobacco Use	___ High Stress Job/Activity	___ Rec Drugs

Have you ever smoked in the past? Y or N Are you currently smoking? Y or N

Authorization and Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment and healthcare operations, and coordination of care. We want you to know how your patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

Name______________________________ Relationship_________________________

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient: __________________________ Date:_________

Guardian's Signature Authorizing Release: ______________________________ Date: ___________________

Informed Consent

The Doctor will use their hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, (also known as Oculosympathetic Palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complain following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to, taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant.

IF YOU ARE PREGNANT, OR THINK YOU MAY BE PREGNANT YOU SHOULD TELL ME OR MY OFFICE STAFF AT THE TIME OF YOUR EXAM.

Printed Patient Name:_______________________ Date: _________________

Patient Signature: ____

Signature of Parent or Guardian (if minor): ________________________________