ADULT NEW PATIENT FORM

Spine by Design Chiropractic

-Health doesn't happen by chance, it happens by design-

Name____________________ Date____/____/______ Age______ Male/Female

Address____________________ City____________________ State____ Zip_______

Phone: Cell____________________ Work ____________________ Home____________________

Email____________________ Date of Birth______/______/________

Employer's Name____________________ Position____________________

Single / Married / Divorced / Widowed Spouse's Name____________________

Number of Children _____ Names, Ages & Gender____________________

Who may we thank for referring you/how did you hear about us? ____________________

REASON(S) FOR SEEKING CARE

Health Concerns: List according to severity	When did this begin?	Have you had this issue before? When?	Rate of Severity 1= mild 10 = unbearable	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.______	______	______	______	______	______
2.______	______	______	______	______	______
3.______	______	______	______	______	______
4.______	______	______	______	______	______

Circle the type of pain you're experiencing: Dull Sharp Ache Numb/Tingly Other: ____________

Is the pain (circle): Worse in the morning Worse in the evening Other: ______________

Since your condition began, has it ______ GOTTEN BETTER ______ GOTTEN WORSE ______ ABOUT THE SAME

What makes it worse? ____________________What makes it better? ____________________

Does your condition affect (circle all that apply): Sleeping Working Walking Sitting Standing Daily Routine

Pain radiates to ____________________ What doctor(s) have you seen for this? ____________________

If you were feeling 100% healthy, what could you do that you cannot currently do? ____________________

____

- I authorize the doctors and staff of Spine by Design Chiropractic to render care as deemed appropriate for me.
- I authorize Spine by Design Chiropractic to release and request records to or from other providers as may be necessary.
- I authorize Spine by Design Chiropractic to release all necessary information to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me.
- I understand I am responsible for all bills incurred in this office.
- I understand Spine by Design Chiropractic follows HIPAA compliance guidelines.

Patient Signature ________________________________ Date ____________________

(This represents a long-term authorization for all occasions of service.)

ADULT NEW PATIENT FORM

HEALTHY HISTORY (Circle all that apply)

ADD/ADHD	DEPRESSION	HIP PAIN	NAUSEA
ALLERGIES	DIABETES	IMMUNE DEFICIENT	NUMBNESS IN LIMBS
ANXIETY	DIZZINESS	INFERTILITY	PREGNANCY ISSUES
ARM PAIN	EAR INFECTIONS	IRRITABLE BOWEL	SCIATICA
ARTHRITIS	EASY BRUISING	KIDNEY PROBLEMS	SCOLIOSIS
AUTISM	EPILEPSY	KNEE PAIN	SINUS INFECTIONS
AUTOIMMUNE	EYE PROBLEMS	LEG PAIN	STOMACH ISSUES
BLADDER PROBLEMS	FATIGUE	LIVER DISEASE	THYROID PROBLEMS
BEDWETTING	FIBROMYALGIA	LOW BACK PAIN	THROAT ISSUES
CANCER	GASTRIC REFLUX	LUPUS	TMJ
CHEST PAIN	HEADACHES	MENSTRUAL ISSUES	ULCERS
CHRONIC FATIGUE	HEART PROBLEMS	MID BACK PAIN	VERTIGO
COLIC	HYPERTENSION	MIGRAINES	WEAKNESS IN LIMBS
OTHER: ___________	_________________	_________________	__________________

PAST HISTORY

List all surgical operations, hospitalizations and date ______________________________

____

List all MEDICATIONS you are currently taking ______________________________

____

When was your last auto accident ______________________________

Have you previously had chiropractic care? YES/NO

If yes, Dr and date______________________________

Have you ever been knocked unconscious? YES/NO Fractured a bone? YES/NO

IF YES, PLEASE DESCRIBE______________________________

____

OTHER TRAUMA______________________________

____

FAMILY HEALTH HISTORY

Father's side: ☐Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_________

Mother's side: ☐Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other_________

Is there any other family history we should know about? ______________________________

____

-FOR OFFICE USE ONLY-

____

____

____

______________________________ ______________________________

STAFF OF SPINE BY DESIGN CHIROPRACTIC DATE

ADULT NEW PATIENT FORM

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOU CHIROPRACTIC HEALTH RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE **VERTEBRAL SUBLUXATIONS**. THESE XRAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. DR. ALBERT DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, HE WILL BRING IT TO YOUR ATTENTION AND REFER YOU TO THE APPROPRIATE SPECIALIST.

____ ________________________

PRINT YOUR NAME HERE **DATE**

____ ________________________

SIGNATURE **AGE**

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, **I BELIEVE I AM NOT PREGNANT** AT THE TIME X-RAYS ARE TAKEN AT SPINE BY DESIGN CHIROPRACTIC CENTER. **DATE OF LAST MENSTRUAL CYCLE**: ____________________

____ ________________________

SIGNATURE **DATE**

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARILY TO CHIROPRACTIC CARE INCLUDES: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIRORPACTIC CARE, AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER FIVE MILLION IS CERVICAL SPINE (NECK) ADJUSTMENTS THAT MAY CAUSE A VERTEBRAL ARTERY INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

____

PRINT PRACTICE MEMBER'S NAME

____ ______________________________

PRACTICE MEMBER'S SIGNATURE **DATE**

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

____ ______________________________

PRACTICE MEMBER'S PARENT/GUARDIAN **DATE**

____ ______________________________

RELATIONSHIP TO MINOR/CHILD **WITNESS SIGNATURE (OFFICE STAFF)**