C-SCHELL CHIROPRACTIC

1169 Walker Road, Dover DE, 19904

(302) 736-1223

New Patient Form

Welcome to our practice! Please thoroughly complete all questions. Thank you.

Name: _____ Date: _____

Full Address: _____

Phone Number: _____ Email (For Appointment Reminders): _____

Birthday: _____ Age: _____ Marital Status: _____ Gender: _____

How did you hear about our office?:

Referral by: _____ Website/Google ☐ Attorney ☐ Physician ☐

Heather's Holistic Health ☐ Internal Staff ☐ Social Media ☐ Other: _____

Hobbies or Interests: _____

Employer Name: _____ Occupation: _____

General Practitioner Name: _____

Specialists under care with: _____

When was the last time you saw a Chiropractor? _____

Who did you see? _____

Health Reasons for consulting our office (Please list according to severity):

1. _____ Rate of Severity (On scale of 1 to 10): _____

2. _____ _____

3. _____ _____

Have you had similar problems before? _____ How long? _____

Any relatives with the same issue(s)? _____ Who? _____

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Is this the result of an auto accident or work injury? _____ When did this injury occur? _____

Other Doctors who have treated this problem: _____

List any previous surgeries: _____

Please check the health concerns you are experiencing:

Dizziness ☐	Throat Issues ☐	Stomach Disorders ☐	Knee Pain ☐	Hip Pain ☐	TMJ ☐
Leg Pain ☐	Headaches ☐	Thyroid Issues ☐	Kidney Problems ☐	Shoulder Pain ☐	Arm Pain ☐
Arm Numbness ☐	Vertigo ☐	Mid-Back Pain ☐	Low-Back Pain ☐	Fibromyalgia ☐	Sciatica ☐
Migraines ☐	Ear Infections ☐	Infertility ☐	Chronic Fatigue ☐	Neck Pain ☐	Disc Problems ☐
Nausea ☐	Hand Numbness ☐	Feet Numbness ☐	Leg Numbness ☐	Chest Pain ☐	Scoliosis ☐
Other:					

Medications you are currently taking: _____

Is there any chance that you are pregnant?: _____

Please check the health conditions you have or had in the past:

Diabetes ☐	Heart Disease ☐	Thyroid Problems ☐	Kidney Problems ☐	Asthma ☐	HIV/AIDS ☐
Stroke ☐	Cancer ☐	High Blood Pressure ☐	Prostate Disorder ☐	Seizure Disorder ☐	Hepatitis A/B/C ☐

Do you have health insurance?: _____ Who is your provider?: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature:_____

I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance. ☐

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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

This notice of privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that is related to your past, present, or future physical or mental health or condition and related services.

Use and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and other uses required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician whom you have been referred to. This is to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for advanced imaging may require that your relevant PHI be disclosed to the health plan to obtain approval for the service.

Healthcare Operations: We may disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limted to, quality assessment activities, employee review activities, training of medical students, licensing, marketing/fund raising activities, and conduction or arranging for patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you about your appointment.

We may use or disclose your PHI in the following situations without your authorization. The situations include as require by law/ required uses and disclosures under law, public health issues. communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation. We must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determined our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative: _____ **Date:**_____

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PATIENT INFORMED CONSENT

Congratulations on choosing Chiropractic Health Care. This clinic believes it is the safest, most natural health care delivery system in the world today.

All health care professionals (anesthesiologist, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any health care risks. It is reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgement. No guarantee of cure has been made to you, the patient of this clinic. Your care may involve the making of recommendations based upon the facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information, the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal, or medical conditions. This clinic, staffed with graduated Chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiologic dynamics of the contiguous, spinal and paraspinal structures to be disturbed. This can cause neuronal disturbances in the form of Vertebral Subluxation Complex (VSC) with its physical components, its chemical components, which can then interrupt the bidy's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, the utilization of specialized instrumentation, lab tests, radiological exams,nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure that is unique to chiropractic: the chiropractic adjustment (chiropractic manipulative theory - CMI). Adjustments are made by Chiropractors to correct and/or reduce and/or stabilize the nerve interference caused by VSC and its component parts. There are over 200 different adjusting techniques, some use specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A CMT is the application of a quick, specific, precise movement over a very short distance to a specific segmental contact point, usually on the vertebra to reduce or stabilize the VSC and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in you informed decision to receive chiropractic care. All health care procedures have some risks. With CMT's, these may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (VAS), Stroke, etc. The chances of this occurring have been generally estimated by experts to be approximately 1 per 250,000 treatments. Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your Doctor of Chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the Doctor's judgement during my course of care, based on the facts they know. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

Patient Name (Printed): _____ **Date:** _____

Patient or Guardian Signature: _____

Once you have completed these forms, please print and bring with you to your next appointment, thank you!