

Name: _____ DOB: _____



New Patient Forms PREGNANCY

Name _____ Date of Birth ____/____/____ Age ____ Male/Female

Address _____ City _____ State _____ Zip _____

Cell Phone Number _____ Home or Work Number _____

Email Address _____ Do you have insurance? ___ Yes ___ No

Social Security # _____ Driver's License # _____

Occupation _____ Employer's Name _____

Single / Married / Divorced / Widowed Spouse's Name _____

Number of Children _____ Names, Ages, & Gender _____

Name & Phone # of Emergency Contact _____

Relationship to Emergency Contact _____

Who may we thank for referring you? _____

Health Conditions

Please identify the health concern(s) that brought you into this office:

Primary: _____ **Second:** _____

Third: _____ **Fourth:** _____

On a scale of 0 to 10 with 10 being the worst and 0 being no pain, rate the above complaints by circling the #:

Primary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did your primary complaint begin? _____

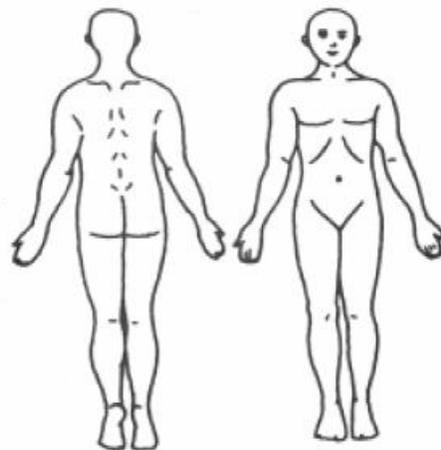
How did the complaint happen? _____

Is your complaint the result of ANY type of accident? ___ Yes ___ No

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching

T = Tingling N = Numbness S = Sharp/Stabbing



Please identify all past and any current conditions you feel may be contributing to your primary complaint:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY
INJURIES			
SURGERIES			

Review of Systems

Please mark: **P** for in the **Past** **C** for **Currently** have

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Impotence/Sexual Dysfun. |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Hepatitis (A,B,C) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Swollen/Painful Joints |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Numb/Tingling arms, hands, fingers | |

Other: _____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the **Past** **C** for **Currently** have

- | | | | | | |
|--------------------------------------|---------------------------------------|--|---|--|-------------------------------------|
| <input type="checkbox"/> Broken Bone | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Tumors | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Fracture | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteo Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cerebral Vascular | |

Other serious conditions: _____

HIPAA Personal Health Information Release Authorization

I, _____, hereby authorize Adjusted Life Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- Spouse Name: _____
- Significant Other Name: _____
- Parent/Legal Guardian Name: _____
- Child(ren) Name(s): _____
- Any Specified Person Name: _____
- Information is not to be discussed with or released to anyone.

Restrictions:

- No Restrictions
- Only discuss my appointment time with the above-named individual(s).
- Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call my home my work my cell phone Phone Number: _____ - _____ - _____
If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call

I understand I may terminate this consent at any time by giving written notice to Adjusted Life Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: 1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. 2. Obtain payment from third-party payers. 3. Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature _____ Date _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. **The fee for copying your x-rays on a disc is \$10.00.** This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Adjusted Life Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print Name _____

Signature _____ Date _____

REGARDING: X-rays / Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient Name (print)

_____ / ____ / ____

Patient or Authorized Person's Signature

Date

Adjusted Life Chiropractic

I hereby authorize payment to be made directly to Adjusted Life Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Adjusted Life Chiropractic for any and all services I receive at this office.

Patient or Authorized Person's Signature

Doctor's Signature

_____ - _____ - _____

Date Completed

_____ - _____ - _____

Date Form Reviewed

Additional Pregnancy Health Information

How many weeks are you currently? _____ What is your anticipated due date? ____ / ____ / ____

What do you call the baby? _____

CONCEPTION & EARLY PREGNANCY

Did you have any difficulty conceiving? ___Yes ___No ___Unknown

Have you used any form of hormonal contraceptives? ___Yes ___No ___Unknown

Have you experienced morning sickness? ___Yes ___No ___Unknown

CURRENT HEALTH INFORMATION

What type of exercise are you currently performing? _____

Please tell us about your current diet, any dietary restrictions? _____

Have you taken or are taking any medication or supplements during your pregnancy? _____

Have you had any slips, falls or other physical traumas during this pregnancy? _____

Have you had any major emotional stressors during this pregnancy? _____

PREVIOUS BIRTH EXPERIENCE

(If multiple previous pregnancies, please explain for each pregnancy if appropriate)

Is this your first pregnancy (circle one)? YES (if yes, please skip this page) NO

If not, how many previous pregnancies? _____

How many children do you have? _____

How many vaginal deliveries? _____ How many cesarean deliveries? _____

Was labor induced using Pitocin? ___Yes ___No ___Unknown

Was there any hip or back pain during labor? ___Yes ___No ___Unknown

Was baby in an optimal position during labor? ___Yes ___No ___Unknown

Did you receive an epidural? ___Yes ___No ___Unknown

If yes, were there any long-term consequences? _____

Were there any operative devices used (i.e., forceps, vacuum)? ___Yes ___No ___Unknown

If yes, please explain: _____

Any post-partum complications or long-term consequences? (circle one)? ___Yes ___No ___Unknown

Any other details you would like to provide?

Do you plan to follow the same plan as your previous delivery (circle one)? ___Yes ___No ___Unknown

If no, what would you like to change? _____

BIRTH PLAN

What are your top 3 goals for this pregnancy? _____

Do you currently have a birth plan? ___Yes ___No ___Unknown

Are you taking any pre-natal or birthing classes? ___Yes ___No ___Unknown

Where will the delivery take place? _____

Who is your OB-GYN or Midwife? _____

Will they be present for the delivery? ___Yes ___No ___Unknown

Who is your birth provider? _____

Do you intend to have a birth coach or doula present? ___Yes ___No ___Unknown

If yes, who? _____

Do you wish to have a medicine free labor & delivery? ___Yes ___No ___Unknown

Who is your support system (i.e., significant other, best friend, parent(s))?

Any concerns?

POST-PARTUM PLAN

Do you plan on breastfeeding your child? ___Yes ___No ___Unknown

What is your timeline for going back to work (if applicable)?

What would you like to gain from chiropractic care during your pregnancy?

Is there anything else you would like to tell us about your pregnancy or birth plan?

Are there any burning questions you want to be sure to ask today?
