ON PURPOSE
CHIROPRACTIC

New Patient Health Record

Welcome to On Purpose and thank you for the opportunity to assist you in improving your health. Chiropractic has helped millions of people of all ages increase the quality of their lives. No one likes paperwork but the more accurate the information you provide the more we will be able to help you. Please ask questions. We look forward to serving you. **Please write legibly!**

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PATIENT INFORMATION

Name_____

Address_____

City_____ State_____ Zip_____

Cell Phone_____

Home Phone_____

Birthdate_____ Age____ Gender_____

Employer_____

Type of Work_____

Marital Status_____ #of kids_____

Email Address_____

Do you have health insurance? ☐Yes ☐No

Carrier_____

If yes please bring your card to your initial exam.

EXPERIENCE WITH CHIROPRACTIC

Who referred you? _____

Have you ever seen a Chiropractor? _____

Dr's Name _____

How often did you go? _____

How long? _____

When was your last visit? _____

Did you bring your family? _____

ABOUT THE SPOUSE OR PARENT

Name _____

Employer_____

Type of Work_____

Cell Phone_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

___Headaches	___ Neck Pain	___ Mid Back Pain	___ Low Back Pain
___ Migraines	___ Allergies/Sinus	___ Asthma	___ Indigestion
___ Tight Muscles	___Fatigue	___ Problem Sleeping	___ Frequent Cold/Flu
___ Ear Infections	___ Cramps/Menstrual	___ Dizziness	___ High Blood Pressure
___ Arthritis	___ Infertility/Irregular	___Constipation/Diarrhea	___ Osteoporosis
___Anxiety/Moody	___ Depression	___ ADD/ADHD	___ Weight Problems
___Tingling/Numb	___ Arms/Hands	___ Legs/Feet	___ Other _____

Which of the above bothers you the most? _____ How long? _____

Describe how it feels or affects you at its worst _____

Does it cause you to be:	___Moody	___ Interrupted Sleep	___ Decreased Productivity
Does this affect your work:	___Decisions/Attitude	___ Exercise/Energy	___ Exhausted at days end
Does this affect your life:	___ Loss of Patience	___ Restricted Activities	___ Restricted Hobbies/Sports

Health Habits

Do you smoke? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No # of days per week ___ What type of exercise? _____

Are you happy with your current weight? ☐ Yes ☐ No What would you like it to be? _____

Would you like assistance achieving your weight goal? ☐ Yes ☐ No

How many hours do you sleep per night? ____ Is your sleep interrupted? ☐ Yes ☐ No

What is your stress level on a scale of 1-10? ____ What is the biggest source? _____

Please list any medications you are taking: _____

Are your health challenges related to a recent accident? _____

Please tell us any health concerns you have for your family members:

Spouse/Partner _____ Children _____

Parents _____ Siblings _____

Other Family/Friends _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method used to attain this objective preventing any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art concerned with the relationship between structure (primarily the spine) and function (primarily the nervous system) and how that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by adjustments. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be recommended. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. It is entirely your responsibility to follow up accordingly with other health care providers.

The one goal of Chiropractic is to correct subluxations of the spine. Diagnosing conditions, treating conditions and relieving pain is not the objective of this practice. Removing nerve interference and improving Nervous system function is the only goal of this practice. Maintaining your health through regular spinal adjustments is our primary concern. Seeking advice from another health care provider cannot and should not interfere with the subluxation corrective care provided by this office.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore consent to examination, X-rays if necessary, and accept any ongoing chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ Signature _____ Date _____