

New Patient



Introduction

Name _____ Date ____/____/____
Name you prefer to be called _____ Age ____ Birthdate ____/____/____ Sex: ☐M ☐F
Street Address _____
City _____ State _____ Zip _____
Phone(____)____-____ ☐ Home ☐ Work ☐ Cell E-mail _____
Employer/School _____ Occupation/Major _____
Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Separated ☐Divorced
Spouse's name _____ Names of children _____
How did you hear of Melby Chiropractic? _____

Current Condition

Describe major complaint: _____
When did this start? ____/____/____ Describe how this began: _____
Severity of complaint (10 is most severe) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Describe the pain: ☐Sharp ☐Stabbing ☐Burning ☐Achy ☐Dull ☐Stiff & Sore ☐Other: _____
Frequency of complaint: ☐Comes and goes ☐Constant
Does this complaint shoot to any areas of your body? ☐ No ☐ Yes (Describe) _____
Does anything make the complaint better? ☐Ice ☐Heat ☐Rest ☐Movement ☐Stretching ☐Medications
☐Other: _____
Does anything make the complaint worse? ☐Sitting ☐Standing ☐Walking ☐Lying ☐Sleep ☐Overuse
☐Other: _____
Which daily activities are being affected by this condition? _____
Have you received any other treatment for this condition? ☐No ☐Yes (Describe) _____
Have you had any previous interventions in this area? ☐No ☐Yes (Describe) _____
Have you taken any medications for this condition? ☐No ☐Yes (Describe) _____
Have you had any diagnostic testing? ☐X-rays ☐MRI ☐CT ☐Other: _____
Describe any other issues you'd like to discuss with Dr. Melby: _____

Pregnancy

Are you pregnant? ☐Yes ☐No ☐Maybe If yes, what is your due date? ____/____/____ Nursing? ☐Yes ☐No

Health History

Notable family health history (cancer, diabetes, heart disease, etc.): _____

List any other significant illnesses or injuries you have had and dates: _____

List any surgeries you have had and dates: _____

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Medications

Medication Name	Dosage

Medication Allergies

Medication Name	Reaction	Onset Date	Additional Comments

Select All That Apply

- | | | |
|--|--|---|
| ☐ Chest pain | ☐ Weakness | ☐ Headache |
| ☐ Shortness of breath | ☐ Seizures | ☐ Dizziness |
| ☐ Fever | ☐ Joint pain | ☐ Vision changes |
| ☐ Unexplained weight loss | ☐ Back pain | ☐ Sleep disturbances |
| ☐ Abnormal Bleeding | ☐ Muscle weakness | ☐ Anxiety/depression |
| ☐ Numbness/tingling | ☐ Stiffness | ☐ Incontinence |

Consent To Treat

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the

cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Receipt of Privacy Practices

I have read and accept the Privacy Notice posted by Melby Chiropractic and authorize the use and/or disclosure of my health information in the manner described therein.

Electronic Health Records

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)

Insurance Authorizations

I request that payment be made on my behalf to Melby Chiropractic for any services furnished to me. This is a direct assignment of my benefits under my policy. This authorization is in effect until I choose to revoke it.

I authorize the release of all pertinent information to any insurance company, adjuster or attorney involved in my case.

Name of Patient (Printed): _____

Signature of Patient: _____ Date: ____/____/____

Name (Printed) of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____ Date: ____/____/____

Signature of Staff Witness: _____ Date: ____/____/____