NEW PATIENT FORM

Print Name: _____ **Date:**_____

Address:_____**City**:_____ **State:** _____**Zip Code:** _____

Home: _____ **Cell:** _____ **Preferred Phone:** H C

Email Address: _____ **Sex:** M F **Marital Status:** M S D W

Date of Birth:_____**Age:**_____ **Social Security #:**_____

Weight:_____ **Height:**_____

Occupation:_____ **Employer**: _____

Referred by: _____ **Have you ever received Chiropractic Care?** (Y) (N)

1. Reasons for seeking chiropractic care: _____

2. Past Health History:

A. Please indicate if you have a history of any of the following:
□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
□ None of the above

B. Previous Injury or Trauma:
_____

Have you ever broken any bones? Which?
_____

C. Medications:_____

D. Surgeries:

Date: Type of Surgery:
_____ _____
_____ _____

E. Females/ Pregnancies :
Are you currently pregnant? (Y) (N) Due Date:_____ **Previous Miscarriages: (Y) (N)**

3. Family Health History:

Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

4. Social and Occupational History:

A. Job Duties: _____

B. Hours worked per week: _____ **Days worked per week:** _____

C. Recreational activities: _____

D. Lifestyle: Smoke: (Y) (N) **Drink:** (Y) (N)

REVIEW OF SYSTEMS

Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems
□Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____
_____

Symptom 1 _____ **(circle one)** Left Right Both Middle

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom:

On Average: 1 2 3 4 5 6 7 8 9 10 At Worst: 1 2 3 4 5 6 7 8 9 10 At Best: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin **suddenly** or **gradually**? **(circle one)**
  - How did the symptom begin? _____
- What makes the symptom worse? **(circle all that apply):**
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? **(circle all that apply):**
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom **(circle all that apply):**
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body **(circle one):** yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? **(circle one)**
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____ **(circle one)** Left Right Both Middle

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom:

On Average: 1 2 3 4 5 6 7 8 9 10 At Worst: 1 2 3 4 5 6 7 8 9 10 At Best: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
  - Did the symptom begin **suddenly** or **gradually**? **(circle one)**
  - How did the symptom begin? _____
- What makes the symptom worse? **(circle all that apply):**
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? **(circle all that apply):**
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom **(circle all that apply):**
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
    Other (please describe): _____
- Does the symptom radiate to another part of your body **(circle one):** yes no
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? **(circle one)**
  - Morning Afternoon Evening Night Unaffected by time of day

INSURANCE POLICY

Health Insurance: We are willing to work with almost all companies that will contribute to your chiropractic care. If you have insurance that covers chiropractic, full payment of services is expected until we verify your specific coverage. Once verified any payment credits you may have will be counted toward your future care. Your specific coverage may take up to 72 hours for verification. We will be happy to offer any assistance in this matter. Please remember, there are many different plans with many different levels of deductibles, Co-payments, Co-insurance and coverage restrictions.

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have

Insurance Company: _____ Identification Number: _____

Name of Subscriber: _____ Birthday of Subscriber: _____

Patients Relationship to Subscriber ❒ Self ❒ Spouse ❒ Child ❒ Other

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or Employee health care benefits coverage with the provided copy, and hereby assign and convey directly to Complete Care Chiropractic/Dr. Adam Atkinson for insurance reimbursement, if any, otherwise payable to me for services rendered from such Doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. **(Signature below)**

HIPAA

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatment you need to read and sign this consent form, stating that you understand and agree with how your records will be used. A more detailed account of our policies and procedures will be given to you upon filling this form and will also be available to you at all times at the front desk.

I have read, agree, and understand that the above information, Insurance Policy, and HIPAA form are all correct:

_____ _____

Signature of Insured/Parent or Guardian Date

Complete Care Chiropractic
Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Adam Atkinson and/or other licensed doctors of chiropractic who now or in the future work at Complete Care Chiropractic or any other office or clinic.

I have had an opportunity to discuss with Dr. Adam Atkinson and/or with other office or clinic personnel about the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also discussed or had an opportunity to discuss its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (or parent/guardian): _____ Date: _____

Patient Name (Print): _____

Witness Signature: _____ Date: _____

Complete Care Chiropractic, Adam Atkinson, DC
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