KARE
CHIROPRACTIC
"Because We Care About Your Health"

New Patient Medical Therapy Paperwork

In order to help determine if you are a good candidate for regenerative/medical medicine treatments, please fill in the information below to the best of your ability.

Today's Date:_____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: ☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Height: _____ Weight: _____

Email: _____

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? ☐ Yes ☐ No

How did you hear about our office? _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Present Complaints:

1. Main Problems: _____

   _____

2. In spite of the fact that you are not a doctor, you are in fact the person that knows more about your condition than anyone else. In your own words and your own opinion, what do you think the real problem is? _____

   _____

3. Symptoms:(List All) _____

   _____

4. Severity of Problem:

   Minimal (annoying but causing no limitation)

   Slight (tolerable but causing a little limitation)

   Moderate (sometimes tolerable but definitely causing limitation)

   Severe (causing significant limitation)

   Extreme (causing near constant limitation (>80% of the time)

5. What relieves your symptoms or causes them to return: _____

   _____

6. Describe the first time you remember having symptoms: _____

   _____

7. If your symptoms include pain:

   What is the quality (Sharp, dull, stabbing, color, ect): _____

   Does the pain radiate? ☐ Yes ☐ No If yes, where? _____

8. Do your symptoms occur at a specific time, place, or environment? ☐ Yes ☐ No If yes, when and for how long do symptoms last each episode? _____

   _____

9. What types of treatment have you received?
   a. Prescription/drug therapy _____
   b. Nutritional _____
   c. Alternative/holistic _____

10. List your health goals in order of importance: _____

    _____

    Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

11. What are you hoping happens today as a result of your consultation? _____

    _____

12. How often are you aware of your main problem (circle one):

    Occasionally (25% of the time)

    Frequently (75% of the time)

    Intermittently (50% of the time)

    Constantly (100% of the time)

13. If you cannot find a solution to your problem what do you think will happen? _____

    _____

14. Due to your condition have you lost time from (describe how much time and what tasks have been limited):

    Work: ☐ Yes ☐ No Describe: _____

    _____

    Family: ☐ Yes ☐ No Describe: _____

    _____

    Leisure Activities: ☐ Yes ☐ No Describe: _____

    _____

Medications(List all prescription, over-the-counter, botanicals, homeopathic, and supplements)

_____

_____

_____

Medical and Social History

Surgeries/Hospitalization Dates: _____

_____

Trauma Date: _____

_____

Past/Recent Illness Date: _____

_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Spouse: _____

Children/Ages: _____

_____

Do you use:

Alcohol ☐ Yes ☐ No How many drinks and how often? _____

Tobacco ☐ Yes ☐ No How many and how often? _____

Caffeine ☐ Yes ☐ No How much and how often? _____

What is your area of greatest pain? _____

_____

What other areas of your body give you pain? _____

_____

Have you been given a diagnosis in the past? ☐ Yes ☐ No

If yes, what was it? _____

What made you want to do something about your pain today? _____

_____

Please mark any and all of the following if you have or have had any:

☐ Cancer	☐ Osteoporosis	☐ Acid Reflux Disease
☐ Kidney/Liver Disease	☐ Sleeping Disorders	☐ Hemodynamic Instability
☐ Immune System Disease	☐ Metabolic Disease	☐ Ulcers
☐ Bone/Joint Problems	☐ Gastrointestinal Disease	☐ Septicemia
☐ Platelet Dysfunction Syndrome	☐ Lung/Pulmonary Disease	☐ Heart Disease
☐ Hypertension	☐ Consistent Use of NSAIDS	☐ Critical thrombocytopenia
☐ Autoimmune Diseases	☐ Other: _____	

Which of the above bothers you the most? _____

_____

What activities would you like to do if this were not a problem? _____

_____

What have you tried to relieve/get rid of this problem?(Check all that apply)

☐ Medications	☐ Physical Therapy	☐ Chiropractic Care
☐ Injections	☐ Exercise	☐ Massage
☐ Nutrition	☐ Stretching	☐ Nothing

☐ Other: _____

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____

Consultation for Regenerative and Medical Services

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for care. There will be a one-on-one consultation with the Doctor to:

- ❖ Review my case history to determine if the practice may be able to help me;
- ❖ Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, ect and discuss my problems and answer questions.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended prior to treatment. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

If applicable, I understand that PRP and Stem Cell therapies are not FDA approved although there are multiple studies shown that this treatment does work.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____

I have been offered and understand the **Patient Health Information Consent Form.**

I have been offered and agree to the **Missed Appointment Policy** and the **$50 fee** associated.

Patient Signature(X): _____ **Date:** _____