



### Chiropractic New Patient Paperwork

Please complete this form to the best of your ability. If you need help our receptionist will gladly assist you!

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: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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? \_\_\_\_\_

When did your condition begin? \_\_\_\_\_

Other Doctors seen for this condition? \_\_\_\_\_

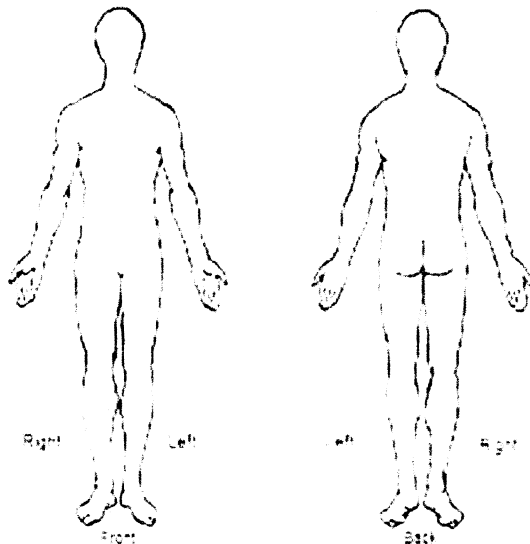
Type of previous Treatment and/or Surgery for this condition? \_\_\_\_\_

Results of previous treatment:  Good  Fair  Poor  Other: \_\_\_\_\_

Have you had the same or similar symptoms before?  Yes  No Date of Prior Condition: \_\_\_\_\_

**MARK AREAS OF PAIN ON THE FIGURE BELOW**

List chief symptoms in order of severity:



- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_

Have you Had Chiropractic care before?

Yes  No

If yes, name of Chiropractor: \_\_\_\_\_

Conditions Treated: \_\_\_\_\_

Results of Treatment: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we forward our findings to your doctor?  Yes  No

Current medications, vitamins, and supplements you are presently taking: \_\_\_\_\_

\_\_\_\_\_

Allergies (medicine, food, environment): \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Do you suffer from any serious conditions and/or illnesses other than which you are now consulting us?

\_\_\_\_\_

Have you been treated for any health conditions in the last year?  Yes  No

If YES, please explain: \_\_\_\_\_

Check all PERSONAL history or any symptoms that apply to you:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headache                             | <input type="checkbox"/> Joint Replacement   | <input type="checkbox"/> Concussion                  |
| <input type="checkbox"/> Cold/Tingling/Numbness in arms/hands | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Metal/Screws/Implants       |
| <input type="checkbox"/> Knocked unconscious                  | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Cervical Whiplash           |
| <input type="checkbox"/> Unexplained weight loss              | <input type="checkbox"/> Electronic Implant  | <input type="checkbox"/> Birth Defects/Complications |
| <input type="checkbox"/> Osteoporosis                         | <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Pacemaker                   |
| <input type="checkbox"/> Cold/Tingling/Numbness in legs/toes  | <input type="checkbox"/> Tumor               | <input type="checkbox"/> Knee Pain                   |
| <input type="checkbox"/> Ruptured Spinal Disc                 | <input type="checkbox"/> Cyst                | <input type="checkbox"/> Slipped Spinal Disc         |
| <input type="checkbox"/> Ear Infections                       | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Pinched Nerve               |
| <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Spinal Injury               |
| <input type="checkbox"/> Loss of Balance/Dizziness            | <input type="checkbox"/> Spinal Infections   | <input type="checkbox"/> Arm Pain                    |
| <input type="checkbox"/> Hip Pain                             | <input type="checkbox"/> Spinal Taps         | <input type="checkbox"/> Leg Pain                    |
| <input type="checkbox"/> Night Sweats                         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Pain Between Shoulders      |
| <input type="checkbox"/> Allergies                            | <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> High Blood Pressure         |
| <input type="checkbox"/> Loss of Sleep                        | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Stomach/Digestive Problems           | <input type="checkbox"/> Fever               | <input type="checkbox"/> Aneurysm                    |
| <input type="checkbox"/> Walking Problems                     | <input type="checkbox"/> Blood in Urine      | <input type="checkbox"/> Convulsions                 |
| <input type="checkbox"/> Fractured Bones                      | <input type="checkbox"/> Night Pain          | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Pain Unrelieved by Rest              | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Memory Lapse                |
| <input type="checkbox"/> Bowel/Bladder Problems               | <input type="checkbox"/> Other: _____        |  |

For Women: Are you pregnant?  Yes  No

Are you taking birth control?  Yes  No

**TREATMENT AUTHORIZATION:**

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amounts become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

**Patient/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NO ACCIDENT OR INJURY:**

I, \_\_\_\_\_, hereby state with my signature below that I was not involved in any motor vehicle accident, slip and fall incident, or work related injury. My treatment here at Kare Chiropractic is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment; therefore, please process and pay all claims immediately.

**If this is due to an accident or injury**, I agree to provide all information needed for billing and treatment including, but not limited to the following:

**Worker's Compensation:**

**Is your condition due to an Employment related injury?**  **Yes**  **No** Have you reported it?  Yes  No

Date of Accident: \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

Supervisor's Phone Number: \_\_\_\_\_

**Auto Accident:**

**Is your condition due to an Automobile Accident?**  **Yes**  **No** Date of Accident: \_\_\_\_\_

Your Auto Policy Insurance Name: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster Phone #: \_\_\_\_\_

Party at Fault's Auto Policy Insurance Name: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster Phone #: \_\_\_\_\_

Adjuster(s) Names: \_\_\_\_\_

Attorney Name(if applicable): \_\_\_\_\_ Phone #: \_\_\_\_\_

**Patient/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_

### INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, may have some level of risk all while offering considerable benefit. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at the rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke. Prior to receiving chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you, along with a care plan, prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary and to the chiropractic care (including spinal manipulations).

**Patient/Parent/Guardian 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/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### CONSENT TO TREAT A MINOR:

I (we) being the parents, guardian or custodian of the minor being:

Name: \_\_\_\_\_ Age: \_\_\_\_\_

do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

**Patient Name(Print):** \_\_\_\_\_

**Parent/Guardian Name(Print):** \_\_\_\_\_

**Patient/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_