

# CHIROPRACTIC

Bringing Out The Best In You

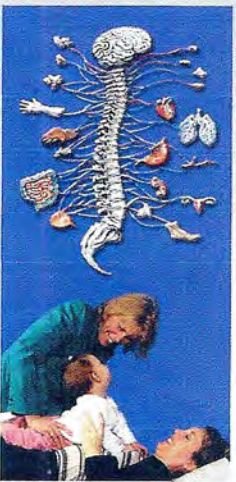
New Patient

## Welcome To Our Office

Patient \_\_\_\_\_

Doctor \_\_\_\_\_

Date \_\_\_\_\_ Case # \_\_\_\_\_



Name \_\_\_\_\_ Preferred name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #s (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Is it okay to contact you at work?  no  yes Work # \_\_\_\_\_

E-mail address \_\_\_\_\_ Web site \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital status  single  married  separated  divorced  widowed

Spouse's name \_\_\_\_\_ Phone #(s) \_\_\_\_\_

Children's names and ages \_\_\_\_\_

Do you have any pets?  no  yes If yes, please tell us what kind(s) \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone #(s) \_\_\_\_\_

Favorite hobbies or interests \_\_\_\_\_

### What Brings You Here?

Have you ever had chiropractic care before?  no  yes

If yes, please tell us the doctor's name \_\_\_\_\_

Were you pleased with your care?  no  yes

How did you find out about our office? \_\_\_\_\_

Is this appointment related to  work  sports  auto

personal injury  other \_\_\_\_\_

When did the incident occur? \_\_\_\_\_

Attorney (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_

Are you receiving care from other health professionals?  no  yes

If yes, please name them and their specialty \_\_\_\_\_

Please list any drugs or medications you are taking \_\_\_\_\_

Please list any vitamins/herbs/homeopathics/other you are taking \_\_\_\_\_

Are you pregnant?  no  yes If yes, what month? \_\_\_\_\_

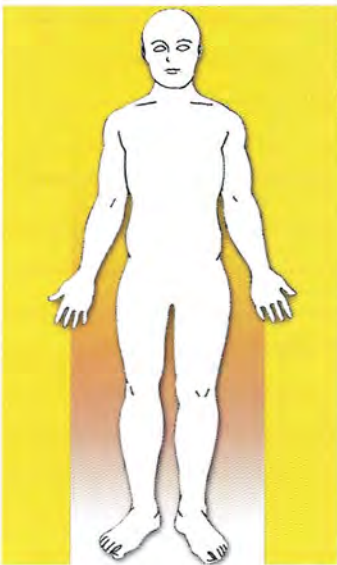
# Current Health

What are your most pressing health concerns? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

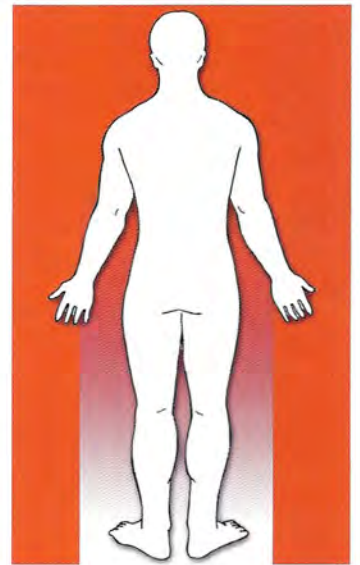
For how long? \_\_\_\_\_

Is it  getting worse  improving  intermittent  
 constant  can't say

Where is the problem? Please use the illustrations and lines below to explain.



Front \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Back \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have  pain  numbness  tingling  aches  
 Is your pain  sharp  dull  throbbing  constant  intermittent  
 Are your symptoms  sitting  standing  walking  
 affected by  bending  lying down  weather

Please explain \_\_\_\_\_

Do you feel  cramps  burning  other  
 swelling  stiffness \_\_\_\_\_

Do your symptoms  work  sleep  other  
 interfere with  day-to-day activities  play \_\_\_\_\_

Please explain \_\_\_\_\_  
 \_\_\_\_\_

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

## Health History

Do you have, or have you had, any of the following (*please check* ✓ *all that apply*)

- |                                 |                               |                                  |                                       |                                |
|---------------------------------|-------------------------------|----------------------------------|---------------------------------------|--------------------------------|
| <input type="radio"/> pneumonia | <input type="radio"/> mumps   | <input type="radio"/> influenza  | <input type="radio"/> rheumatic fever | <input type="radio"/> smallpox |
| <input type="radio"/> pleurisy  | <input type="radio"/> polio   | <input type="radio"/> chickenpox | <input type="radio"/> thyroid disease | <input type="radio"/> diabetes |
| <input type="radio"/> epilepsy  | <input type="radio"/> cancer  | <input type="radio"/> depression | <input type="radio"/> whooping cough  | <input type="radio"/> anemia   |
| <input type="radio"/> eczema    | <input type="radio"/> measles | <input type="radio"/> arthritis  | <input type="radio"/> heart disease   | <input type="radio"/> rashes   |

If you have ever been diagnosed with another disease or condition, please describe \_\_\_\_\_

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- Do you use
- |                               |                                  |   |                             |
|-------------------------------|----------------------------------|---|-----------------------------|
| <input type="radio"/> coffee  | <input type="radio"/> tea        | <input type="radio"/> artificial sweeteners | <input type="radio"/> sugar |
| <input type="radio"/> alcohol | <input type="radio"/> cigarettes | <input type="radio"/> recreational drugs    |                             |

Have you ever suffered from (*please check* ✓ *all that apply*)

- |   |   |  |
|---|---|--|
| <input type="radio"/> neck pain               | <input type="radio"/> stuffy nose         | <input type="radio"/> discolored urine         |
| <input type="radio"/> low back pain           | <input type="radio"/> allergies           | <input type="radio"/> gas/bloating after meals |
| <input type="radio"/> headache                | <input type="radio"/> fainting            | <input type="radio"/> heartburn                |
| <input type="radio"/> migraines               | <input type="radio"/> weight loss         | <input type="radio"/> colitis                  |
| <input type="radio"/> arm back/tingling       | <input type="radio"/> poor appetite       | <input type="radio"/> irritable bowel          |
| <input type="radio"/> shoulder pain           | <input type="radio"/> excessive appetite  | <input type="radio"/> black or bloody stools   |
| <input type="radio"/> hand pain/tingling      | <input type="radio"/> nervousness         | <input type="radio"/> constipation             |
| <input type="radio"/> leg pain/tingling       | <input type="radio"/> confusion           | <input type="radio"/> hemorrhoids              |
| <input type="radio"/> jaw pain                | <input type="radio"/> depression          | <input type="radio"/> liver problems           |
| <input type="radio"/> chest pain              | <input type="radio"/> dental problems     | <input type="radio"/> stroke                   |
| <input type="radio"/> lung problems           | <input type="radio"/> excessive thirst    | <input type="radio"/> paralysis                |
| <input type="radio"/> heart problems          | <input type="radio"/> frequent nausea     | <input type="radio"/> tingling                 |
| <input type="radio"/> abnormal blood pressure | <input type="radio"/> vomiting            | <input type="radio"/> numbness                 |
| <input type="radio"/> irregular heartbeat     | <input type="radio"/> prostate problem    | <input type="radio"/> fatigue                  |
| <input type="radio"/> ankle swelling          | <input type="radio"/> breast pain/lump    | <input type="radio"/> dizziness                |
| <input type="radio"/> cold extremities        | <input type="radio"/> cramps              | <input type="radio"/> loss of sleep            |
| <input type="radio"/> blurred vision          | <input type="radio"/> painful urination   | <input type="radio"/> difficulty hearing       |
| <input type="radio"/> vision problems         | <input type="radio"/> bladder trouble     | <input type="radio"/> ear pain                 |
| <input type="radio"/> difficulty breathing    | <input type="radio"/> excessive urination |  |

If applicable, date of last menstrual period \_\_\_\_\_

Past injuries can affect present health (*please check* ✓ *all that apply*)

- |   |   |   |
|---|---|---|
| <input type="radio"/> falls/accidents         | <input type="radio"/> head injuries         | <input type="radio"/> fights            |
| <input type="radio"/> sports injuries         | <input type="radio"/> broken bones          | <input type="radio"/> dislocations      |
| <input type="radio"/> spinal tap              | <input type="radio"/> surgery               | <input type="radio"/> traction          |
| <input type="radio"/> use(d) a cane or walker | <input type="radio"/> extensive dental work | <input type="radio"/> dental appliances |
| <input type="radio"/> knocked unconscious     |   |   |

If yes to any of the above, please describe \_\_\_\_\_

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# What Do You Know About Chiropractic?



In your own words, what do chiropractors do? \_\_\_\_\_

\_\_\_\_\_

Do you know what spinal nerve stress/subluxation is?       no     yes

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do any friends or relatives see chiropractors?       no     yes

If yes, do they use chiropractic for       health maintenance/optimization

health problems     both

Are you seeking chiropractic for       health maintenance/optimization

health problems     both

What would you like to gain from chiropractic care? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there other health concerns or anything else you'd like us to know about you?

no     yes    If yes, please tell us. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Financial Responsibility

Who is responsible for payment? \_\_\_\_\_

How will you pay for your care?

Cash     Check     Credit Card # \_\_\_\_\_ Exp. \_\_\_\_\_

Insurance co. \_\_\_\_\_ Group Policy # \_\_\_\_\_

Address \_\_\_\_\_ Policy ID # \_\_\_\_\_

Insured's name \_\_\_\_\_ Phone # \_\_\_\_\_

Relation \_\_\_\_\_ Insured's employer \_\_\_\_\_

The above is accurate to the best of my knowledge.

\_\_\_\_\_

(signature)

(date)

I, parent/guardian, give permission for minor's care.

\_\_\_\_\_

(signature)

(date)

# FAMILY HEALTH HISTORY

Patient \_\_\_\_\_ Date \_\_\_\_\_

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	FATHER AGE__	MOTHER AGE__	SPOUSE AGE__	BROTHER(S) AGE__ AGE__		SISTER(S) AGE__ AGE__		CHILDREN AGE__ AGE__ AGE__		
<b>First Name</b>										
<b>Condition</b>										
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emotional Problems										
Emphysema										
Epilepsy										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Liver Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

**Acknowledgment of  
Receipt of  
Notice of Privacy Practices**

I, \_\_\_\_\_ hereby acknowledge that I received a copy of the Back 2 Health Chiropractic HIPPA Notice of Privacy Practices.

Date: \_\_\_\_\_ Signature of Patient/Patient's Representative

**Regarding the Use & Disclosure  
of Protected  
Health Information**

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care options, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

**I understand that in the event that my health insurance does not cover services that are provided in our clinic, I personally am responsible for any outstanding balances. If I accrue any type of balance in our clinic, I fully understand and agree to pay such balance promptly once received. I also understand and approve of that if the balance goes to a collection agency, any fees associated with such service, attorney fees etc. will be billed to me as a patient.**

Patient Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent to Treatment

I authorize the performance of examination, x-ray (when needed), and chiropractic treatment to be performed by, or under the direction of, Dr. Franzen and Dr. Chris Toler and/or such doctors/paraprofessionals/assistants as may be selected by the doctor to perform such professional procedures, as he/she deems necessary.

I recognize that during the course of procedure unforeseen conditions may necessitate additional or different procedures/services than those set forth above and I further authorize and request Dr. Franzen/Dr. Chris Toler to perform such procedures as are in his/her professional judgment necessary and desirable.

The nature, purpose and possible consequences of the procedures, possible alternative methods of treatment, the risk involved and the possibility of complications have been fully explained to me by my attending doctor of chiropractic.

No guarantees or assurances have been made or given by anyone as to the specific results that may be obtained and none are promised.

I, the undersigned, have read and understand the contents of this authorization.

\_\_\_\_\_  
Patient or authorized person signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship (if other than patient)

\_\_\_\_\_  
Date