



## New Patient Paperwork

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

Patient: \_\_\_\_\_  
Last Name
First Name
Initial

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

City/State/Zip Code: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Email: \_\_\_\_\_ Newsletter?  Y  N

Insured's Name: \_\_\_\_\_  
Last Name
First Name
Initial

### Present Complaints (Please circle the appropriate ones)

Headache/Migraine  
 Mental dullness  
 Loss of memory  
 Dizziness/Vertigo/Meniere's  
 Ears ringing/buzzing  
 Upper/Mid/Lower back pain  
 Post Concussion/Whiplash  
 Other \_\_\_\_\_  
 Pins and needles in hands  
 right/left

Feet/Hands Cold  
 Depression  
 Rib pain  
 Nervousness  
 Eye strain/pain  
 Shortness of breath  
 Fear/Confusion  
 TMJD/Jaw  
 Pins and needles in arms  
 right/left

Unbalanced  
 Fainting  
 Blurred vision  
 Irritability  
 Double vision  
 Loss of smell  
 Chest pain  
 Neck pain  
 Pins and needles in legs  
 right/left

**Medical Implants:** \_\_\_\_\_

**Medical alerts:** \_\_\_\_\_

**Surgical Implants:** \_\_\_\_\_

**Pregnancy:** yes \_\_\_\_ no \_\_\_\_

**PAIN SCALE:** Rate the severity of your pain by checking a box on the following scale.

<b>No Pain</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Excruciating Pain</b>
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**Medications:** (please list all medications and supplements that you currently take)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** (please list all medications that cause allergic reaction)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Smoking:** \_\_\_ Yes \_\_\_ No If yes, \_\_\_\_\_ Packs per Day for \_\_\_\_\_ years

**Alcohol** \_\_\_ Yes \_\_\_ No If yes, Number of drinks per week \_\_\_\_\_

**Surgical History:** Please list ALL previous surgery and the date on which it was performed:

Surgery \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal Medical History & Review of Systems:**

Please indicate with an "X" any medical problems that you currently have or have had in the past.

**NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

**Lungs / Pulmonary – breathing disorders**

- asthma
- COPD
- emphysema
- pulmonary embolism
- pneumonia
- tuberculosis
- respiratory arrest
- sleep apnea
- other: \_\_\_\_\_

**Cardiac / Heart and peripheral vascular disease**

- chest pain / angina
- heart attack, myocardial infarction
- congestive heart failure
- other: \_\_\_\_\_
- high blood pressure
- heart murmur, valve disorder
- mitral valve prolapse
- bleeding problems
- irregular heartbeat, arrhythmia
- peripheral vascular disease
- deep vein thrombosis

**Neurologic Disorders**

- stroke or TIA
- peripheral neuropathy
- other: \_\_\_\_\_
- parkinson's
- MS
- cerebral palsy
- polio

**Bone & Joint Disorders**

- osteoarthritis
- rheumatoid arthritis
- other: \_\_\_\_\_
- gout
- lupus
- osteomyelitis
- ankylosing spondylitis



**Gastrointestinal Disorders**

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: \_\_\_\_\_
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type \_\_\_\_\_
- liver disease

**Genitourinary Disorders**

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: \_\_\_\_\_

**Metabolic & Other Disorders**

- Diabetes x \_\_\_\_\_ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- Cancer : any type -- please specify \_\_\_\_\_
- skin disorder \_\_\_\_\_
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: \_\_\_\_\_

Other medical problems NOT included above (explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- other heart : \_\_\_\_\_
- Peripheral neuropathy
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- hepatitis - Type \_\_\_\_\_
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- Cancer : any type -- please specify \_\_\_\_\_
- tuberculosis
- other lung : \_\_\_\_\_
- congestive heart failure
- bleeding problems
- MS or Parkinson's
- Lupus
- Other bone & joint: \_\_\_\_\_
- inflammatory bowel disease
- other GI : \_\_\_\_\_
- dialysis, kidney failure
- psoriasis
- sickle cell disease
- sleep apnea
- other neuro : \_\_\_\_\_
- gout
- high cholesterol or lipids
- any skin ulcer

Other medical problems NOT included above (explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** \_\_\_\_\_

**INDICATE PAST CHIROPRACTIC CARE:**

- Traditional Chiropractic
- NUCCA
- None

**PATIENT INSURANCE INFORMATION:**

Please check any and all insurance coverage you or your spouse has applicable in this case.

- Medicare Part B
- Auto Insurance

Insurance Identification Number: \_\_\_\_\_

**AUTO INSURANCE:**

Date of Accident: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Adjuster: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**PRIMARY CARE PROVIDER:**

Provider Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

**LEGAL INFORMATION:**

Attorney Name & Address: \_\_\_\_\_

\_\_\_\_\_

Attorney Phone #: \_\_\_\_\_

\*Person to contact in an emergency (Name and Phone #): \_\_\_\_\_

\_\_\_\_\_



### Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. 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 in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. We will assess your specific condition, your overall health, and, in particular, your spinal health. This will assist us in determining if NUCCA care is needed, or if any further examinations or studies are needed before initiating care. 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 program of care prior to any treatment.

We do not offer to diagnose or provide care for any disease or condition other than your Subluxations. However, if during the course of evaluation and care we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

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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 upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

Patient  
Name: \_\_\_\_\_

Patient  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_

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**Do not Write Below this line**

**Office use Only**

Witness Signature (Office Staff): \_\_\_\_\_ Date: \_\_\_\_\_