Longevity Chiropractic New Patient Form

_____**DATE**___/___/____

Title: (Check one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____ **Work Phone (_____)** _____

Cell Phone (_____) _____ **Carrier** _____ **Email** _____

Preferred method of contact? ☐**Text** ☐**Call** ☐**Email** **Sex:** ☐ Male ☐ Female

Date of Birth _____/_____/_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Employer Data_

Name _____

Your Occupation _____ **Job Description** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (_____) _____ **Cell Phone (_____)** _____

IF Worker's Compensation Injury / Auto / or Personal Injury:

Have you filed an injury report with your employer? ☐Yes ☐No Date: ____/____/____ Time: _____am /pm

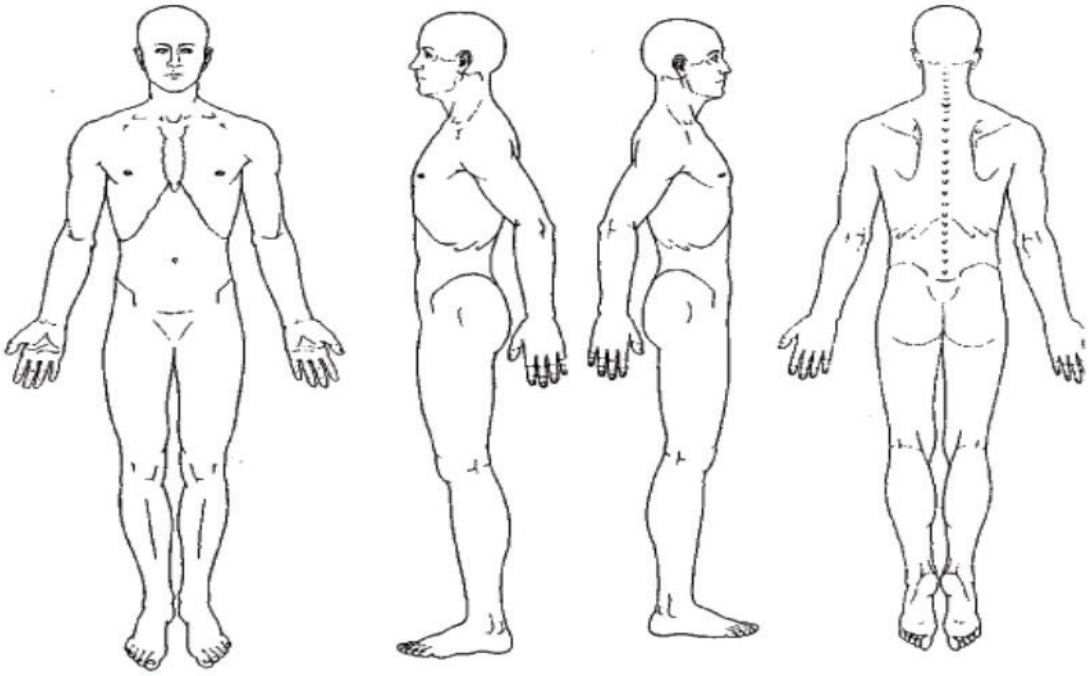
Have you spoke to an attorney regarding your car accident? ☐Yes ☐No Date: ___/____/____Time: _____am /pm

How did you hear about our office? _____

Patient Name_____ **Date**_____

Using the key below, indicate on the body diagram where you are experiencing pain and symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Briefly describe your symptoms:

_____

_____

_____

WHAT caused your symptoms? ☐ Car accident ☐ Work injury ☐ Trauma ☐ Other

Please describe:

_____

_____

WHEN did your symptoms begin? _____

Since then, have your symptoms: ☐ Improved ☐ Gotten Worse ☐ Stayed about the same

Have you ever experienced something like this before? ☐Yes ☐No **If so, when?** _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What activities make your symptoms **BETTER**? _____

What activities make your symptoms **WORSE**? _____

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Moderate/Severe** (limited duty) ☐ **Severe** (Unable to perform)

Previous Surgeries: _____

Previous Hospitalizations: _____

Other Accidents / Traumas: _____

Have you had an X-rays or MRI taken before? ☐Yes ☐No If yes, what for? _____

Does the condition interfere with your sleep? ☐Yes ☐No If yes, explain: _____

Do you crack your own neck, back, or any other part of your body? ☐Yes ☐No How often? _____

How do you usually sleep? ☐ Back ☐ Stomach ☐ R / L Side How many pillows do you use? ____

Do you regularly exercise, stretch, or participate in any fitness programs? ☐Yes ☐No

If you put yes, briefly describe what type of exercise(s) you do:

_____

What sports did you play in the past, and for how many years? _____

Previous occupations: _____

Do you currently take any vitamins or supplements on a regular basis? If so, list what type(s):

_____

Do you wear foot orthotics? ☐Yes ☐No ☐ I did in the past, but not anymore

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _____

Social History: (Check all that apply to you)

Caffeine use:	☐ Never	☐ Occasionally	☐ Often
Drink Alcohol:	☐ Never	☐ Occasionally	☐ Often
Exercise:	☐ Never	☐ Occasionally	☐ Often
Chew Tobacco:	☐ Never	☐ Occasionally	☐ Often
Cigarettes:	☐ Never	☐ Occasionally	☐ Often

Other: _____

Do you follow a special diet or have any restrictions on what you eat? _____

How much water do you drink per day? _____ Do you drink soda or soft drinks? ☐Yes ☐No

Please list all current medications being taken:

_____

Are you experiencing any side effects? ☐Yes ☐No If so, what? _____

Patient Name_____ **Date**_____

Review of Systems – (Check box if you have had trouble with any of the following, check NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo / Dizziness				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Has anyone in your immediate family suffer from any of the following: Cancer – Heart Condition - Hypertension (High blood pressure)– Liver or Kidney disease – Diabetes – Neurologic disorder

If so, who? _____

Patient Name_____**Date**_____

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self ☐ Health Insurance ☐ Spouse ☐ Worker's Comp
☐ Auto Insur. ☐ Medicare ☐ Medicaid ☐ Other _____

Personal Health Insurance Carrier: _____ Insur. Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____ / _____ / _____ Primary Care Physician _____

HIPAA Privacy Practices (Please Sign and Date)

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name _____

Patient's Signature _____
Date_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Guardian / Spouse's Signature Authorizing Care _____
Date_____

SIGNATURE OF PHYSICIAN: _____Date: _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic X-rays on me (or on the patient named below, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: muscle soreness, fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all the risks and complications involved, and I know that results are not guaranteed or immediate. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I understand that throughout treatment there may be periods of time when I may feel old symptoms return, or new symptoms emerge. Muscle soreness may switch sides, or appear in new locations. I may even feel tired, sleepy, emotional, or worn down after treatment.

***I understand that this is all normal part of the healing process as my body is going* through physiological changes.**

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient (Or guardian):

Print Patient's Name: _____

Signature of Patient: _____ Date _____

To be completed by the patient's representative, if patient is a minor:

Print Name of Representative: _____

Signature of Representative: _____ Date _____