



New Patient Paperwork
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Personal Information

Name _____ Date _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email Address _____
Contact Pref. H_ W_ C_ Email_ Birth Date __/__/____ Age __
Marital Status (circle one) Single Married Divorced Widowed
of Children and Ages _____
Employer _____ Occupation _____

Other Information

Emergency Contact _____ Relation _____ Phone _____
How were you referred to our office? _____
Have you ever been to a chiropractor? Y_ N_ Who? _____ When _____
If yes, were the results satisfactory? _____
Long-term goal of this appointment _____

Primary Care Physician

Physician: _____ Phone: _____
May we update them on your condition? Y_ N_

INJURY INFORMATION

Describe your major complaint _____
When did your problem begin? (specific date if possible) _____
How did your problem begin? _____

What increases your pain? _____ decreases? _____

How many days a week do you experience pain/discomfort? _____ days

Are your symptoms ___ Decreasing ___ Not Changing ___ Increasing

Symptoms are worse in the ___ Morning ___ Afternoon ___ Evening ___ Same all day

Has your daily activity changed as a result of your condition? If so, please explain.

No ___ Yes _____

PAIN CHART

Please Mark the Areas of Pain using these Symbols & Mark Severity of Pain to the Left
 +++ Burning XXX Dull/Ache /// Numbness/Tingling === Throbbing 000 Stabbing/Sharp

SEVERITY OF PAIN

1. Complaint _____

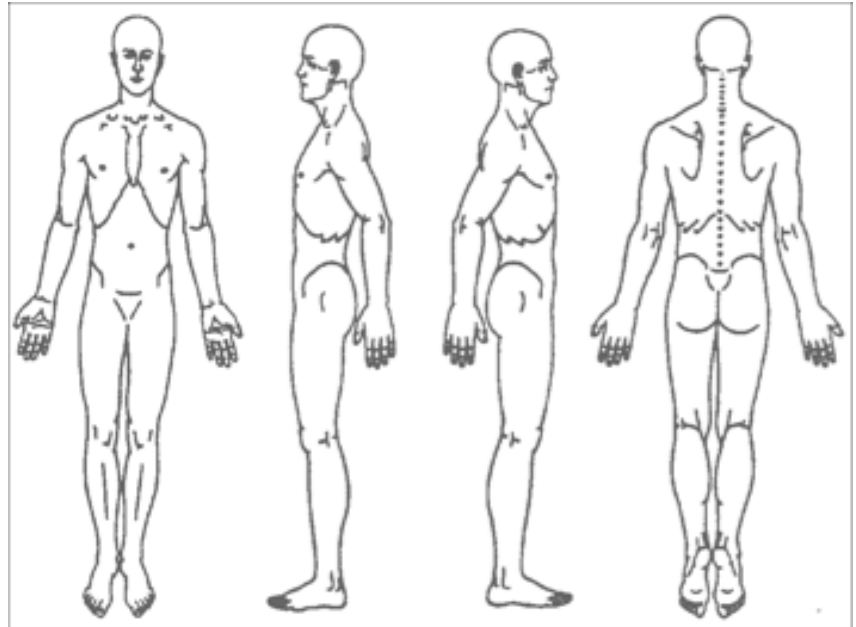
←————→
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

2. Complaint _____

←————→
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

3. Complaint _____

←————→
 No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable



Have you detected any possible relationship of your current complaint with any of the following:

___ Bowel/Bladder problems ___ Digestion ___ Cardiac/Respiratory ___ Other: _____

What treatments have you previously tried for this condition?

Physical Therapy ___ Chiropractic ___ Massage ___ Orthopedic ___ Family/Primary Doctor ___
 Other _____

If so, please write name _____

Have you had Spinal X-Rays, MRI, CT SCAN? ___ No ___ Yes:

Date(s) taken: _____ Area(S) taken _____

Condition(s) being treated:

List all prescription, non-prescription medications and other supplements you take as well associated condition:

List any surgeries or hospitalizations you have had including month and year:

Family

History: _____

Do you exercise: ___ Yes ___ No Hours per week? ___

What activities: _____

Are you dieting? ___ Yes ___ No Since? ___

Do you smoke? ___ Yes ___ No Packs per day? ___ How many years? ___

Do you drink alcoholic beverages? ___ Yes ___ No Drinks per day ___

How much water do you drink in a day? _____

Are you currently pregnant? ___Y ___N *Who is your current OBGYN/Mid-Wife/Doula? _____

* All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any pay- able benefits. I further understand that payment may be less than the actual cost of services and will be responsible for any outstanding amount owed this office.

Patient Signature: _____ Date: _____

Financial/Privacy Policy & Disclaimer and Authorization

Payment

- Due at Time of Service

Returned Checks

- It is our policy to collect \$25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a \$20 charge added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator.

HIPAA Privacy Policy

- Available at the front desk is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has had the HIPAA Privacy Policy made available to him/her and will comply with our financial policies.

Designation of Authorized Representative

- I do hereby designate CHC to the full extent permissible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to obtain any medical records that are pertinent to my current condition that has led me to seek care from CHC.
- You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.

patient signature

date

Functional Exam

Name _____ Date _____ Doctor _____

Gait/Posture

6 inch Step

ROM

Modified Thomas

MRS

Hip ABD

HIP EXT/Int Rot

Muscles

Shoulder ABD

-TrP

Quad Rock/Push-up

-Weak/Inhibited

TMJ

-Overactive

Other Test (ortho/fxnal//DNS)

Motion Palpation

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