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Please complete and return to our patient facilitator at the front desk

New Patient Information

Title you prefer: Mr. Mrs. Miss Ms. Dr. Pastor Marital Status: Married Single Divorced Widowed

Patient Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

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

Cell Phone (_____) _____ E-Mail: _____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: _____ - _____ - _____ Birth date: ____/____/____ Age: ____

Employer: _____ Occupation: _____

Who may we thank for referring you? _____

Spouse Information

Spouse's Name: _____
Legal First Middle Last Nickname

Social Security #: _____ - _____ - _____ Birth Date: ____/____/____ Age: ____

Employer: _____ Occupation: _____

Cell Phone (_____) _____ Work Phone (_____) _____

Parent Information (If patient is 18 or under)

Parent Name: _____
Legal First Middle Last Nickname

Address: _____
Street City State Zip

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

Cell Phone (_____) _____ E-Mail: _____

Which phone number do you prefer we use to contact you? Home Cell Work

Sex: Male Female Social Security #: _____ - _____ - _____ Birth date: ____/____/____ Age: ____

Employer: _____ Occupation: _____

Closest Living Relative (Someone not living with you, in case of emergency.)

Name: _____ Relationship: _____

Home Phone (_____) _____ Cell Phone (_____) _____

Other Information

Have you ever been diagnosed with cancer? _____ If yes, when? _____

Auto Accident Information

Was a police report filed? No ___ Yes ___ Were there other people in the car? No ___ Yes ___ How Many? _____

Whose fault was the accident? Yours ___ The driver of other car ___ The driver of car you were in ___

Do you have Med-Pay? Yes ___ No ___ Amount? _____

Your Med-Pay Information

Company _____

Address _____

City/St/Zip _____

Policy # _____

Claim # _____

Phone #: _____

Adjuster _____

Other Party's Insurance Information

Company _____

Address _____

City/St/Zip _____

Policy # _____

Claim # _____

Phone # _____

Adjuster _____

Attorney Information

Name: _____ Phone: _____

Address: _____

Date and time of the accident? ____/____/____ ____:____ AM/PM Number of vehicles involved: _____

Was your vehicle totaled? ___ No ___ Yes, estimated damage \$ _____

Street or intersection name: _____ What direction were you traveling? _____

City and State of accident: _____

Type of impact: _____ my vehicle was rear-ended _____ my vehicle rear-ended another vehicle
_____ my vehicle was hit on driver side _____ my vehicle hit another vehicle on driver side
_____ my vehicle was hit on passenger side _____ my vehicle hit another vehicle on passenger side
_____ my vehicle was hit head on _____ my vehicle hit another vehicle head on

Did your vehicle hit anything after the accident? ___ no If yes, please describe _____

Where were you sitting in the vehicle during the accident? ___ Driver ___ Front Passenger ___ Back Left Passenger ___
Back Right Passenger ___ Other _____

Mark one of the following: _____ I was unaware the accident was coming. _____ I was aware of the impending accident and relaxed. _____ I was aware of the impending accident and braced myself.

What type of vehicle were you in? _____ What type of vehicle impacted yours? _____

Was your vehicle? ___ slowing down ___ stopped ___ gaining speed ___ moving at a steady speed

Was the other vehicle? ___ slowing down ___ stopped ___ gaining speed ___ moving at a steady speed

At time of impact, how fast were you going? _____ How fast was the other vehicle going? _____

During and after the crash what happened to your vehicle? (Check all that apply) ___ kept going straight ___ spun around
___ kept going straight hitting a car in front ___ spun around and hit a stationary object ___ was hit by another vehicle
___ hit a stationary object ___ other _____

Patient Name: _____

DOB: ___/___/___

Did you lose consciousness during the accident? ___ No ___ Yes If yes, how long were you unconscious? _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

How were your hands positioned during the accident? _____

Did any area of your body hit anything in or out of the vehicle during the accident? ___ No ___ Yes If yes, please mark which area and where in or out of the vehicle you hit: ___ head _____ ___ face _____
___ neck _____ ___ chest _____ ___ arm L/R _____ ___ wrist L/R _____ ___ hip L/R _____
___ knee L/R _____ ___ foot L/R _____

What kind of headrest was in your vehicle? ___ movable fixed headrest ___ non-movable fixed headrest
___ no headrest

Where was the headrest positioned on your head? ___ top-back of head ___ middle height-back of head
___ lower portion-back of head ___ level-back of neck ___ level-shoulder blades

Was your seatbelt on during the accident? ___ No ___ Yes If yes what type of seatbelt: ___ shoulder/lap
___ lap ___ baby car seat ___ booster seat ___ cannot remember

Did you slide out of your seatbelt? ___ No ___ Yes, completely ___ Yes, partially Other: _____

What was damaged in your vehicle? (Check all that apply)

___ windshield ___ steering wheel ___ dashboard ___ seat frame ___ side window
___ rear window ___ mirror ___ knee bolster ___ rear bumper ___ front bumper
___ trunk ___ front left door ___ front right door ___ back left door ___ back right door
___ completely totaled ___ other _____

Which doors would not open as a result of the accident: ___ front left ___ front right ___ rear left ___ rear right
___ trunk ___ tailgate

Did you go to the hospital? ___ No ___ Yes if yes, please continue answering questions on this page.

How did get to the hospital? ___ ambulance ___ helicopter ___ police car ___ friend drove ___ drove self
___ walked

What was the name of the hospital? _____ Were you hospitalized over night? ___ Yes ___ No

What you were prescribed at the hospital? ___ pain meds ___ muscle relaxor ___ neck brace ___ back brace

Did you receive any stitches for any cuts at the hospital? _____

Were x-rays taken at the hospital? If yes, which area was x-rayed? _____

Was an MRI performed? If yes, on which area was the MRI? _____

Did you receive any special imaging? If yes, on which area was the special imaging? _____

May we request x-ray, MRI, special imaging reports, if needed? ___ Yes ___ No

Patient Name: _____

DOB: ____/____/____

Please fill in complaint area for complaints you currently have resulting from the accident dated ____/____/____.

Complaint Area #1: _____

How often do you experience your symptom? Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain? Sharp Numb Dull Tingly Diffuse Shooting Achy Shooting with motion Burning Stabbing with motion Sharp with motion Stiff Electric like with motion
 Other: _____

How is your symptom changing with time? Worse Staying the Same Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
 Not at all A little bit Moderately Quite a bit Extremely

How much has your symptom interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #2: _____

How often do you experience your symptom? Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain? Sharp Numb Dull Tingly Diffuse Shooting Achy Shooting with motion Burning Stabbing with motion Sharp with motion Stiff Electric like with motion
 Other: _____

How is your symptom changing with time? Worse Staying the Same Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
 Not at all A little bit Moderately Quite a bit Extremely

How much has your symptom interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____

DOB: ____/____/____

Complaint Area #3: _____

How often do you experience your symptom? Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain? Sharp Numb Dull Tingly Diffuse Shooting Achy Shooting with motion Burning Stabbing with motion Sharp with motion Stiff Electric like with motion
 Other: _____

How is your symptom changing with time? Worse Staying the Same Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
 Not at all A little bit Moderately Quite a bit Extremely

How much has your symptom interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Complaint Area #4: _____

How often do you experience your symptom? Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

How would you describe the type of pain? Sharp Numb Dull Tingly Diffuse Shooting Achy Shooting with motion Burning Stabbing with motion Sharp with motion Stiff Electric like with motion
 Other: _____

How is your symptom changing with time? Worse Staying the Same Better

Using a scale from 0-10 (10 being the worst), rate the intensity of your symptom? _____

How much has your symptom interfered with your work?
 Not at all A little bit Moderately Quite a bit Extremely

How much has your symptom interfered with your social activities?
 Not at all A little bit Moderately Quite a bit Extremely

Name and type of healthcare provider have you seen for this symptom: _____

How long have you had this symptom? _____ **How do you think this symptom began?** _____

Do you consider this problem to be severe? ____ No ____ Yes ____ Yes at times

What aggravates this symptom? _____ **What alleviates this symptom?** _____

What concerns you most about this symptom? _____

Patient Name: _____

DOB: ____/____/____

How would you rate your overall Health? Excellent Very Good Good Fair Poor

What type of exercise do you do? Strenuous Moderate Light None

Place a check if any of your immediate family members have the following:

RA Diabetes Lupus Heart Problems Cancer ALS

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past Present

- Headaches
- Neck Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Elbow/Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Upper Leg Pain
- Knee Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Pain/Stiffness
- Arthritis
- Rheumatoid Arthritis
- Cancer
- Tumor
- Asthma
- Chronic Sinusitis
- Other: _____

Past Present

- High Blood Pressure
- Heart Attack
- Chest Pains
- Stroke
- Angina
- Kidney Stones
- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Abnormal Weight Gain/Loss
- Loss of Appetite
- Abdominal Pain
- Ulcer
- Hepatitis
- Liver/Gall Bladder Disorder
- General Fatigue
- Muscular Incoordination
- Visual Disturbances
- Dizziness

Past Present

- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- Allergies
- Depression
- Systemic Lupus
- Epilepsy
- Dermatitis/Eczema/Rash
- HIV/AIDS

For Females Only

- Birth Control Pills
- Hormonal Replacement
- Pregnancy

List all prescription and over-the counter medications you are currently taking: _____

List all vitamins and other supplements you are currently taking: _____

What activities do you do at work? (check all that apply)

- | | | | |
|-------------------|---------------------|---------------------|-------------------------|
| ___ Travel a lot | ___ Read a lot | | |
| ___ Sit | ___ Most of the day | ___ Half of the day | ___ A little of the day |
| ___ Stand | ___ Most of the day | ___ Half of the day | ___ A little of the day |
| ___ Computer Work | ___ Most of the day | ___ Half of the day | ___ A little of the day |
| ___ Use the Phone | ___ Most of the day | ___ Half of the day | ___ A little of the day |

What activities do you do outside of work? (check all that apply)

- ___ Housework/laundry ___ Fixing/building things
 ___ Reading ___ Watching TV ___ Exercising, describe _____
 ___ Take care of children ___ Other _____

Have you seen a Chiropractor before? ___ No ___ Yes If yes, how long ago? _____

What were the results? ___ Great ___ Good ___ Fair ___ Mixed ___ Poor ___ Other: _____

List all hospitalization, surgical procedures and significant past traumas: _____

Is there anything else the doctor needs to know about you or your health? _____

I verify these statements are true to the best of my knowledge:

Signature _____

Date: _____

Patient or Parent/Guardian

Symptoms

Patient Name _____

DOB ____/____/____

Please mark complaint area for complaints you currently have resulting from the accident on ____/____/____.

Orthopedic & Musculoskeletal Symptoms

- ___ "Clunk" Sound with Neck Movements
- ___ Neck Pain
- ___ Upper Back Pain
- ___ Low Back Pain
- ___ Shoulder Pain ___ Left ___ Right
- ___ Upper Arm Pain ___ Left ___ Right
- ___ Elbow Pain ___ Left ___ Right
- ___ Forearm Pain ___ Left ___ Right
- ___ Wrist Pain ___ Left ___ Right
- ___ Hand Pain ___ Left ___ Right
- ___ Hip Pain ___ Left ___ Right
- ___ Upper Leg Pain ___ Left ___ Right
- ___ Knee Pain ___ Left ___ Right
- ___ Lower Leg Pain ___ Left ___ Right
- ___ Ankle Pain ___ Left ___ Right
- ___ Foot Pain ___ Left ___ Right
- ___ Jaw Pain
- ___ Clicking in Jaw
- ___ Pain when Chewing
- ___ Face Pain
- ___ Chest Pain
- ___ Stomach Pain
- ___ Bruise/Contusion to _____
- ___ Abrasion /Scrape to _____
- ___ Other Symptom _____
- ___ Other Symptom _____

Neurological Symptoms

- ___ Numb/Tingling Arm / Hand L R
- ___ Numb/Tingling Leg / Foot L R
- ___ Weakness Arm / Hand L R
- ___ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ___ Range of Motion Problems
- ___ Headaches
- ___ Muscle Spasms
- ___ Dizziness
- ___ Visual Disturbances
- ___ Sleep Disruption
- ___ Radiating Pain
- ___ Anxiety
- ___ Depression
- ___ I am taking over-the-counter pain meds

Brain/Neuropsych/MTBI Symptoms

- ___ Wanting to be Alone
- ___ Sleepiness
- ___ Nausea/Vomiting
- ___ Difficulty Concentrating
- ___ Day Dreaming/Staring Mindless Staring
- ___ Mood Swings
- ___ Agitation
- ___ Sadness or tearful
- ___ Blurry Vision
- ___ Double Vision
- ___ Disoriented
- ___ Confused
- ___ Difficulty Speaking
- ___ Feelings of Isolation from Others
- ___ Attention Problems
- ___ Appetite Changes
- ___ Pupils Different Sizes
- ___ Room Spins/Woozy Feeling
- ___ Balance Problems
- ___ Difficulty Walking
- ___ Difficulty Focusing/Easily Distracted
- ___ Very Tired
- ___ Dozing During the Day
- ___ Personality Change
- ___ Can't Remember Numbers
- ___ Reading Problems
- ___ Writing Problems
- ___ Difficulty with Adding/Subtracting
- ___ Poor Attention
- ___ Difficulty Learning New Things
- ___ Difficulty Understanding
- ___ Difficulty Remembering Things
- ___ Re-reading things to understand it
- ___ Anger
- ___ Difficulty Making Decisions
- ___ Change in Sexual Functioning
- ___ Reduced Confidence
- ___ Helplessness
- ___ Apathy (Don't Care)
- ___ Irritable
- ___ Change in Sense of Taste or Smell
- ___ Flashbacks to Accident
- ___ Impatience
- ___ Frustration
- ___ Hearing Problems
- ___ Difficulty Planning or Organizing



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Terms of Acceptance

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(Signature)

_____/_____/_____
(Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period:

_____/_____/_____

(Signature)

_____/_____/_____
(Date)



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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Print Name: _____ Date _____/_____/_____