

ADULT NEW PATIENT FORM

Spine by Design Chiropractic

-Better health by design-

Name _____ Date ____/____/____ Age _____ Male/Female
Address _____ City _____ State _____ Zip _____
Phone: Cell _____ Work _____ Home _____
Email _____ Date of Birth ____/____/____
Employer's Name _____ Position _____
Single / Married / Divorced / Widowed Spouse's Name _____
Number of Children _____ Names, Ages & Gender _____
Who may we thank for referring you/how did you hear about us? _____

REASON(S) FOR SEEKING CARE

Health Concerns: List according to severity	When did this begin?	Have you had this issue before? When?	Rate of Severity 1 = mild 10 = unbearable	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

Circle the type of pain you're experiencing: Dull Sharp Ache Numb/Tingly Other: _____

Is the pain (circle): Worse in the morning Worse in the evening Other: _____

Since your condition began, has it _____ GOTTEN BETTER _____ GOTTEN WORSE _____ ABOUT THE SAME

What makes it worse? _____ What makes it better? _____

Does your condition affect (circle all that apply): Sleeping Working Walking Sitting Standing Daily Routine

Pain radiates to _____ What doctor(s) have you seen for this? _____

If you were feeling 100% healthy, what could you do that you cannot currently do? _____

- I authorize the doctors and staff of **Spine by Design Chiropractic** to render care as deemed appropriate for me.
- I authorize **Spine by Design Chiropractic** to release and request records to or from other providers as may be necessary.
- I authorize **Spine by Design Chiropractic** to release all necessary information to any insurance company, attorney or adjuster for the purpose of claim reimbursement of charges incurred by me.
- I understand I am responsible for all bills incurred in this office.
- I understand **Spine by Design Chiropractic** follows HIPAA compliance guidelines.

Patient Signature _____
(This represents a long-term authorization for all occasions of service.)

Date _____

ADULT NEW PATIENT FORM

HEALTHY HISTORY (Circle all that apply)

ADD/ADHD	DEPRESSION	HIP PAIN	NAUSEA
ALLERGIES	DIABETES	IMMUNE DEFICIENT	NUMBNESS IN LIMBS
ANXIETY	DIZZINESS	INFERTILITY	PREGNANCY ISSUES
ARM PAIN	EAR INFECTIONS	IRRITABLE BOWEL	SCIATICA
ARTHRITIS	EASY BRUISING	KIDNEY PROBLEMS	SCOLIOSIS
AUTISM	EPILEPSY	KNEE PAIN	SINUS INFECTIONS
AUTOIMMUNE	EYE PROBLEMS	LEG PAIN	STOMACH ISSUES
BLADDER PROBLEMS	FATIGUE	LIVER DISEASE	THYROID PROBLEMS
BEDWETTING	FIBROMYALGIA	LOW BACK PAIN	THROAT ISSUES
CANCER	GASTRIC REFLUX	LUPUS	TMJ
CHEST PAIN	HEADACHES	MENSTRUAL ISSUES	ULCERS
CHRONIC FATIGUE	HEART PROBLEMS	MID BACK PAIN	VERTIGO
COLIC	HYPERTENSION	MIGRAINES	WEAKNESS IN LIMBS
OTHER: _____	_____	_____	_____

PAST HISTORY

List all surgical operations, hospitalizations and date _____

List all MEDICATIONS you are currently taking _____

Have you ever been in an auto accident YES/NO

If yes, When was it and briefly describe _____

Have you previously had chiropractic care? YES/NO

If yes, Dr and date _____

Have you ever been knocked unconscious? YES/NO Fractured a bone? YES/NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA _____

FAMILY HEALTH HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other _____

Is there any other family history we should know about? _____

-FOR OFFICE USE ONLY-

ADULT NEW PATIENT FORM

STAFF OF SPINE BY DESIGN CHIROPRACTIC

DATE

X-RAY AUTHORIZATION

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE STRESS AND DYSFUNCTION IN THE SPINE. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. DR. ALBERT DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS. HOWEVER, IF ANY ABNORMALITIES ARE FOUND, HE WILL BRING IT TO YOUR ATTENTION AND REFER YOU TO THE APPROPRIATE SPECIALIST.

PATIENT NAME

PATIENT SIGNATURE

DATE

FEMALE PATIENTS ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME X-RAYS ARE TAKEN AT SPINE BY DESIGN CHIROPRACTIC CENTER.

SIGNATURE

DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS 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 SECONDARILY TO CHIROPRACTIC CARE INCLUDES: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE, AT A RATE OF ONE INSTANCE PER TEN MILLION IS CERVICAL SPINE (NECK) ADJUSTMENTS THAT MAY CAUSE A VERTEBRAL ARTERY INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. 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.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN BELOW

PATIENT'S PARENT/GUARDIAN NAME

DATE