NEW LEAF CHIROPRACTIC
PATIENT HEALTH RECORD

PATIENT INFORMATION DATE:_____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: (HOME)_____ (CELL)_____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

EXPERIENCE WITH CHIROPRACTIC

How did you hear about our office? _____

Who may we thank for referring? _____

Have you been adjusted by a chiropractor before? Yes☐ No ☐ Date of last visit: _____

Reason for those visits? _____

INSURANCE INFORMATION

Do you have health insurance? Yes ☐ No ☐ Name of Carrier: _____

Member ID: _____

Do you have secondary insurance? Yes ☐ No ☐ Name of Carrier: _____

Member ID: _____

ASSIGNMENT AND RELEASE (Insured Patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAL/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all the necessary information, including the diagnosis and the records or any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature of Patient/Guardian _____ **Date**_____

REASON FOR THIS VISIT

Describe the purpose of this visit_____

_____

When did this condition begin? _____

Is the purpose of this appointment related to: ☐ Job ☐ Sports ☐ Auto ☐ Fall

☐ Home Injury ☐ Chronic Discomfort ☐ Other

Has this condition:

☐ Gotten worse ☐ Stayed constant ☐ Comes and goes

Does this condition interfere with:

☐ Work ☐ Sleep ☐ Daily routine ☐ Other activities

Has this condition occurred before? ☐ Yes ☐ No

Please rate your pain on a scale of 1 to 10 (0 = no pain, 10 = extreme)

☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

How do your symptoms affect your ability to perform daily activities? (0=no effect, 10=inability to perform activities)

☐1 ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10

HEALTH HISTORY

Please check each of the diseases or conditions that the patient is currently experiencing or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall evaluation, care plan and the possibility of being accepted for care.

☐Severe or frequent headaches	☐ Kidney problems	☐Sinus problems	☐Shingles
☐Ulcers/ colitis	☐ Asthma	☐Loss of sleep	☐Pain between shoulders
☐High/ Low High blood pressure	☐ Difficulty breathing	☐Frequent Neck Pain	☐ Numbness
☐Frequent Colds	☐Heart attack/stroke	☐Arthritis	☐ Dizziness
☐ Heart surgery/ pacemaker	☐Tuberculosis	☐Digestive problems	☐Chemotherapy
☐Congenital heart defect	☐Hepatitis	☐Diabetes	☐ Pain in arms/legs/hands
☐Lower back problems	Surgeries_____		

HEALTH HABITS

Do you smoke? ☐Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No

Do you drink coffee, tea or soda? ☐Yes ☐ No

Do you exercise regularly? ☐Yes ☐ No

Do you wear: ☐Lifts ☐Inner soles ☐ Arch supports

For Women:

Are you pregnant? ☐Yes ☐ No

Are you nursing? ☐Yes ☐ No

Are you taking birth control? ☐Yes ☐ No

Do you experience painful periods? ☐Yes ☐ No

Do you have irregular cycles? ☐Yes ☐ No

Do you have breast implants? ☐Yes ☐ No

MEDICATIONS

Please check medications you are currently taking.

☐Cholesterol Medication	☐Blood pressure medicine	☐Stimulants
☐Blood thinners	☐Tranquilizers	☐Pain Killers (including aspirin)
☐Muscle Relaxers	☐Insulin	

Vitamins and Supplements _____

_____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come to simply ease their pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms corrected (Corrective Care). Our team of Doctors will weigh your needs and desires when recommending your treatment plan.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care_____ Corrective Care_____ Check here if you want the Doctor to select your care_____

NEUROLOGICAL, MRI, AND VASCULAR PATIENT QUESTIONNAIRE

For any YES answer, please include details.

1. Do you suffer from neck pain, with pain in your shoulder, arms, or hands? ☐Yes ☐ No
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐Yes ☐ No
   Comment: _____
3. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐Yes ☐ No
   Comment: _____
4. Do you suffer from a loss of handgrip strength? ☐Yes ☐ No
   Comment: _____
5. Do you suffer from back pain with pain in your buttocks, legs, or feet? ☐Yes ☐ No
   Comment: _____
6. Do you have weakness, numbness or burning in your buttocks, legs, or feet? ☐Yes ☐ No
   Comment: _____
7. Do you have reduced feeling (sensation) or swelling in your legs or feet? ☐Yes ☐ No
   Comment: _____
8. Do you suffer from cold hands or feet? ☐Yes ☐ No
   Comment: _____
9. Do you have frequent falls or find that you trip over your feet while walking? ☐Yes ☐ No
   Comment: _____
10. Do you suffer from headaches? If yes, how often, how severe, what has been tried? ☐Yes ☐ No
    Comment: _____
11. Have you tried any medications such as anti-inflammatory? If yes, what medication? ☐Yes ☐ No
    Comment: _____

12. Have you ever tried any Physical Therapy or Chiropractic treatments before? ☐Yes ☐ No
    Comment: _____
13. Have you had an MRI? ☐Yes ☐ No
    If yes: When? Who ordered it? What was it ordered for?
    Comment: _____

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release Of Information

☐I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐Spouse_____ ☐Child(ren)_____

☐Other_____ ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Witness (Office Staff) **Date**

INFORMED CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber, and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

_____ _____

Signature of Patient/Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices.

(Please initial one of the following options and sign below)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_____ _____

Signature of Patient/Guardian **Date**

CHIROPRACTIC CONSENT TO CARE

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 include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instances per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care from this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your musculoskeletal health. These procedures will assist us in determining what 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. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with physical medicine and give consent to the examinations that the doctor deems necessary, to include chiropractic care involving spinal adjustments, as reported following my assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

Signature _____ **Date** _____