

NEW PATIENT INFO. & MEDICAL HX-PI

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F)
 Address _____
(number) (street) (city) (state) (zip code)
 Social Security# _____ - _____ - _____ Birth Date ____ / ____ / ____ Age _____
 Phone # (____) _____ - _____ Cell # (____) _____ - _____ Email _____
 Married () Single () Other () _____ Spouse's Name _____
 Occupation _____ Employer _____ Work Address _____

IN CASE OF AN EMERGENCY, CONTACT _____
Name Relationship Phone #

Have you ever had chiropractic care before? (YES / NO) If yes, when was your last treatment? _____
 Have you ever had a professional massage before? (YES / NO) If yes, when was your last massage? _____
 What are your health goals? (Check one of the following)
 Reduce symptoms only Reduce symptoms and show me how to prevent flair-ups Reduce symptoms, prevent flair-ups and maintenance care

Do you have any type of health insurance? (YES / NO) Primary Insurance _____ Secondary Insurance _____
 Is this injury work related? (YES / NO) Is this injury due to a motor vehicle accident? (YES / NO)
*** IF YOU ANSWERED YES TO EITHER OF THE TWO PREVIOUS QUESTIONS, PLEASE NOTIFY THE FRONT DESK ***

MEDICAL HISTORY

Check any of the following symptoms you are currently experiencing or have experienced within the past 6 months.

- | | | | | |
|--|---|--|--|--|
| <p><u>Musculoskeletal</u>
 ___ Low Back Pain
 ___ Pain Between Shoulders
 ___ Neck Pain
 ___ Headaches
 ___ Arm Pain/Numb/Tingling
 ___ Leg Pain/Numb/Tingling
 ___ Joint Pain/Stiffness
 ___ Walking Problems
 ___ Difficulty Chewing
 ___ Weakness</p> <p><u>EENT</u>
 ___ Vision Problems
 ___ Dental Problems
 ___ Sore Throat
 ___ Ear Pain/Ringing
 ___ Hearing Difficulty</p> | <p><u>General</u>
 ___ Allergies
 ___ Loss of Sleep
 ___ Fever/Night Sweats
 ___ Eczema (skin rash)
 ___ Weight Loss/Gain</p> <p><u>Genitourinary</u>
 ___ Bladder Trouble
 ___ Painful Urination
 ___ Excessive Urination
 ___ Discolored Urine</p> <p><u>Male Specific</u>
 ___ Difficulty Urinating
 ___ Impotence
 ___ Sterility</p> | <p><u>C-V-R</u>
 ___ Chest Pain
 ___ Short of Breath
 ___ Blood Pressure
 ___ Heart Problems
 ___ Wheezing
 ___ Lung Problems
 ___ Varicose Veins
 ___ Arm/Leg Swelling
 ___ Asthma
 ___ High Cholesterol
 ___ Bruise Easily</p> <p><u>Female Specific</u>
 ___ Menstrual Irregularity
 ___ Menstrual Cramping
 ___ Sterility
 ___ Breast Pain</p> | <p><u>Nervous</u>
 ___ Numbness
 ___ Paralysis
 ___ Dizziness
 ___ Forgetfulness
 ___ Confusion
 ___ Depression
 ___ Fainting
 ___ Convulsions
 ___ ADHD/Hyperactivity
 ___ Anxious
 ___ Tremor/Shaking</p> | <p><u>Gastrointestinal</u>
 ___ Gas/Bloating
 ___ Heartburn
 ___ Poor Appetite
 ___ Excessive Appetite
 ___ Excessive Thirst
 ___ Decreased Appetite
 ___ Colitis
 ___ Vomiting
 ___ Diarrhea
 ___ Constipation
 ___ Black/Bloody Stool
 ___ Hemorrhoids
 ___ Liver Problems
 ___ Abdominal Pain
 ___ Frequent Nausea</p> |
|--|---|--|--|--|

ARE YOU PREGNANT? (YES / NO)

Name of your family physician _____ Last appointment with your physician _____ Phone # _____ Fax # _____
 Do you give us permission to send your medical doctor an updated report on your status? (YES / NO)
 Have you been hospitalized in the past? (YES / NO) If yes when and why? _____
 Please list any surgeries you have had and when.

 Please list any medications you are taking.

PATIENT SIGNATURE _____ **DATE** _____

NEW PATIENT COMPLAINT(S)

Name _____ (Complete #1-10) Date _____

1. What is your **worst** complaint? _____

When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) **Occasionally** **Intermittently** **Frequently** **Constantly**
(0-25% of the day) (26-50% of the day) (51-75% of the day) (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

2. What is your **second worst** complaint? _____

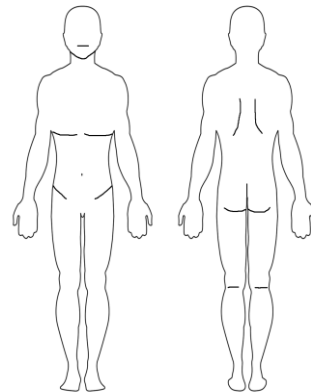
When and How did your condition begin? _____

Rate your pain/discomfort on the scale. (circle) (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe)

How often do you experience this complaint? (circle) **Occasionally** **Intermittently** **Frequently** **Constantly**
(0-25% of the day) (26-50% of the day) (51-75% of the day) (76-100% of the day)

How are your symptoms changing? (circle) **Improving** **Not Changing** **Worsening**

3. Briefly describe any other complaints. _____



4. How much have these symptoms interfered with the following activities? (check all that apply)

Work

Social Activities

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> Not at all |
| <input type="checkbox"/> A little bit | <input type="checkbox"/> A little bit |
| <input type="checkbox"/> Moderately | <input type="checkbox"/> Moderately |
| <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Quite a bit |
| <input type="checkbox"/> Extremely | <input type="checkbox"/> Extremely |

5. Circle any other symptoms you are experiencing.

- (Sharp Pain) (Dull Ache) (Shooting Pain)
 (Burning Pain) (Throbbing Pain) (Popping) (Weakness)

6. Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain XXX **Numbness OOO** **Tingling √√√**
Stiffness /// **Burning +++**

7. Who have you seen for your symptoms?(check) No One Medical Doctor Chiropractor Physical Therapist Other

a. What treatment did you receive and when? _____

b. Circle any tests have you had for your symptoms? (X-Rays) date:____ (CT Scan) date:____ (MRI) date:____ (Other)

8. Have you had similar symptoms in the past? (YES / NO)

If yes, when was the last time you experienced those symptoms? _____ How long did your symptoms last? _____

9. What is your occupation? _____ Are you required a disability note for your employer / teacher? (YES / NO)

10. **Family History:** Does anyone in your immediate family (including your grandparents) have any of the conditions listed? (Circle all that apply)

Arthritis, Asthma, Birth Defects (i.e. heart defects), Cancer, Diabetes, Genetic Conditions (i.e. Cystic Fibrosis), Heart Disease, Mental Illnesses (i.e. Alzheimer's, Parkinson's), Obesity, Seizures

DOCTORS NOTES: _____

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PRIVATE PRACTICES/ BUSINESSES

There are separate practices/ businesses within this office. Each entity is owned and operated as separate businesses and may have separate fee schedules, different treatment techniques and patient management. I understand that each service offered at this facility are owned and operated as separate businesses and hold each business harmless from any act or omission which may occur by any of the other businesses during the course of my treatment at this facility. Circumstances may arise such as emergencies, or doctor vacation or sick leave and you may request to be treated by another doctor within this office. If you are treated by another doctor you may be charged a different fee. Please consult with our office manager before your treatment if you have any questions.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I consent to the performance of chiropractic examination, adjustments/ manipulation, massage, nutritional recommendations and all other chiropractic procedures permitted by our State law, including medical records review, various modes of physiotherapy and necessary diagnostic x-rays on myself (or on the patient named below, for whom I am legally responsible for) by any of the treating doctors of chiropractic on staff and/ or any licensed chiropractor deemed appropriate by the office.

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic.

- A) While rare, some patients may experience short term aggravation of symptoms, ligament and muscle strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;
- B) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;
- C) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence have demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;
- D) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

CONSENT TO TREAT MINOR

I, _____ the parent or legal guardian, who has permission to make medical decisions for _____, a minor child, authorize any necessary treatment at Maxwell Chiropractic for my minor child and fully agree to the above terms.

PRINT NAME

SIGNATURE

DATE

Maxwell Chiropractic

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name: _____

Date of Birth: _____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Maxwell Chiropractic**.

I understand that the Notice describes the uses and disclosures of my protected health information by **Maxwell Chiropractic** and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative

Printed Name of Patient or that of Legal Representative

Today's Date

If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement
- Communications barriers prohibited obtaining the acknowledgement
- Other (please specify): _____

Employee Name

Today's Date