

# PATIENT INTRODUCTION CARD

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ **Circle One:** Married Single Other

Email address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Office Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Previous chiropractic care? **Circle One:** Yes No If yes, Doctor's name \_\_\_\_\_

Major Complaint \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged.***

# REVIEW OF SYSTEMS HEALTH QUESTIONNAIRE

Please check each of the conditions below that you are currently experiencing.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
File No: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

### ARE YOU PREGNANT?

\_\_\_\_\_ YES \_\_\_\_\_ NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

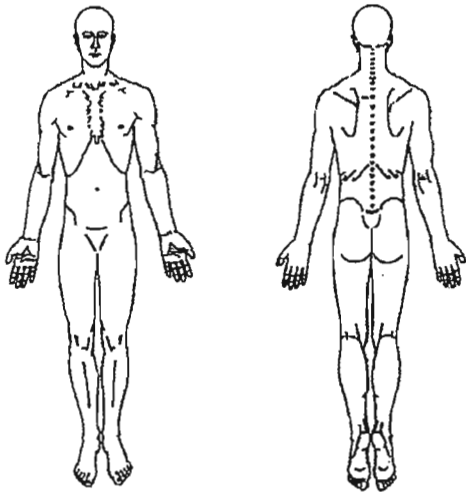
### EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus problems
- Allergy
- Jaw pain

## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

### SYMPTOM LOCALIZATION



P \_\_\_\_\_ Pain                      T \_\_\_\_\_ Tender  
N \_\_\_\_\_ Numbness              H \_\_\_\_\_ Hypoesthesia  
S \_\_\_\_\_ Spasm

### Pain Index:

LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Patient's Signature: \_\_\_\_\_

# New Patient History

## Current Condition

1. Do you have a main complaint? If yes, what is it?  
\_\_\_\_\_
2. When did you first notice your symptoms? What happened?  
\_\_\_\_\_
3. What helps your condition?  
\_\_\_\_\_
4. What aggravates your condition?  
\_\_\_\_\_
5. Is your pain sharp or dull?  
\_\_\_\_\_
6. Do you have any numbness, pins and needles, or tingling in your arms or legs?  
\_\_\_\_\_
7. Where is your pain located?  
\_\_\_\_\_
8. Is your pain constant or does it come and go?  
\_\_\_\_\_
9. Have you seen another doctor for this condition in the past 3 years?  
\_\_\_\_\_
10. Do you have any pain or problems with your: jaw, hands, wrists, elbows, shoulders, hips, knees, ankles, and/or feet?  
\_\_\_\_\_
11. Please list any prescriptions or supplements you have taken in the past six months.  
\_\_\_\_\_

## Past Medical History

1. When was your last car accident?  
\_\_\_\_\_
2. Have you been hospitalized or had any injuries in the past 3 years?  
\_\_\_\_\_

## Social and Family History

1. Do you smoke, use recreational drugs, or alcohol?  
\_\_\_\_\_
2. Do you have a family history of: arthritis, diabetes, hypertension, stroke, heart disease, cancer, and/or any other disease or condition?  
\_\_\_\_\_

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care 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 vertebrae 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 diseases or conditions other than vertebral subluxation. However, if during the course of 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 health care 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 chiropractic method is specific adjusting to correct vertebral subluxation.

I, \_\_\_\_\_, have read and fully understand the above statement.  
(PRINT NAME)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any and necessary reports and forms to assist me in making collections from the insurance company and that any amount to be paid directly to this Chiropractic 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, and fees for professional services rendered to me will be immediately due and payable.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## HIPPA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operation. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of the Consent.

**This consent was signed by:** \_\_\_\_\_

**Printed Name-Patient or Representative**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**