

Last Name:

ADULT NEW PATIENT PAPERWORK

Date: _____

Name: _____
Last First M.I

Address _____

E-mail (please provide for communication purposes) _____

Cell Phone: _____ Home Phone: _____

Sex: _____ Male _____ Female Age: _____ Birthdate: _____

Occupation: _____

Text messaging is our preferred method of communication, is that ok or do you prefer phone? Text _____ Phone _____

How did you find out about our clinic? _____

Emergency Contact: _____ Relationship: _____ Phone _____

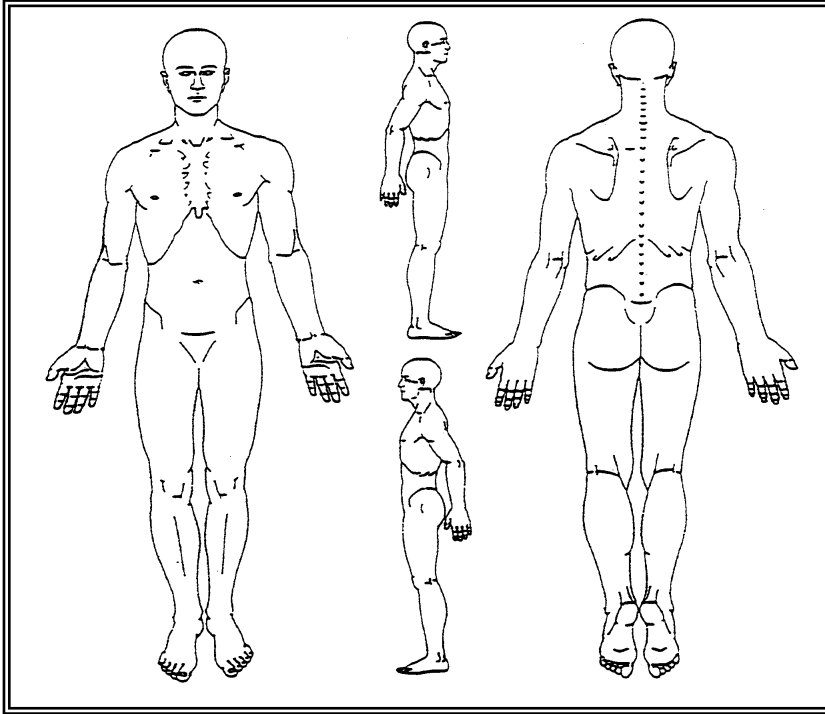
What are your main health goals for the next 6 months while working with Dr. Julie?

- | | |
|--|---|
| <input type="checkbox"/> Movement/stretching | <input type="checkbox"/> Help with nutrition |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Balance/Core Stability |
| <input type="checkbox"/> Better exercise/movement | <input type="checkbox"/> Detoxing |
| <input type="checkbox"/> More sleep/better quality | <input type="checkbox"/> Old Injury Recovery/Scar Tissue |
| <input type="checkbox"/> More energy | <input type="checkbox"/> Recovery from previous illness/virus |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Please indicate the main reason you are seeing us today: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX // // // // // O O O O O O O O S S S S S -----
 DULL/ACHY SHARP/STABBING NUMBNESS/TINGLING STIFF/TIGHT BURNING



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

- 0 = No Pain. No Discomfort
- 1 = Minimal Discomfort. Minor stiffness or tightness.
- 2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain. More than just sore. Uncomfortable.
- 4 = Mild Pain. Noticeable pain but tolerable.
- 5 = Moderate Pain. Aggravating. Still allows movement.
- 6 = Strong Pain. Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain. Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
- 9 = Severe Pain. Brings tears. Almost impossible to move.
- 10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Sources of Physiological Stress:

| <u>Emotional/Mental</u> | <u>Physical Trauma/Falls/Accidents</u> | <u>Toxins/Chemical Exposure</u> |
|--|---|--|
| <input type="checkbox"/> work environment/employment | <input type="checkbox"/> birth or childhood injuries | <input type="checkbox"/> harsh chemical cleaners |
| <input type="checkbox"/> home related/kids/family | <input type="checkbox"/> vehicle accidents: yr(s) _____ | <input type="checkbox"/> tobacco/alcohol/drug usage |
| <input type="checkbox"/> relational | <input type="checkbox"/> sports injuries | <input type="checkbox"/> pets and allergies |
| <input type="checkbox"/> psychological | <input type="checkbox"/> work injuries | <input type="checkbox"/> environmental/building toxins |
| <input type="checkbox"/> spiritual | <input type="checkbox"/> virus/illness/disease | <input type="checkbox"/> medications _____ yrs |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> other _____ | <input type="checkbox"/> other _____ |

Medical Symptoms Questionnaire

Patient Name _____

Date _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

Point Scale

- 0 - Never or almost never have the symptom
- 1 - Occasionally have it, effect is not severe
- 2 - Occasionally have it, effect is severe
- 3 - Frequently have it, effect is not severe
- 4 - Frequently have it, effect is severe

| | | |
|--|---|---|
| HEAD _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia Total _____ | ENERGY/ACTIVITY _____ Fatigue, Sluggishness _____ Apathy, Lethargy _____ Hyperactivity _____ Restlessness Total _____ | LUNGS _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing Total _____ |
| EYES _____ Watery or Itchy Eyes _____ Swollen, Reddened or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (does not include near or far-sighted) Total _____ | WEIGHT _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight Total _____ | HEART _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain Total _____ |
| EARS _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss Total _____ | EMOTIONS _____ Mood Swings _____ Anxiety, Fear, Nervousness _____ Anger, Irritability, Aggressiveness _____ Depression Total _____ | DIGESTIVE TRACT _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloating Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain Total _____ |
| NOSE _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation Total _____ | MIND _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty in Making Decisions _____ Stuttering or Stammering _____ Slurred Speech _____ Learning Disabilities Total _____ | OTHER _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge Total _____ |
| MOUTH/THROAT _____ Chronic Coughing _____ Gagging, Frequent Need to Clear Throat _____ Sore Throat, Hoarseness, Loss of Voice _____ Swollen or Discolored Tongue, Gums/Lips _____ Canker Sores Total _____ | JOINTS/MUSCLE _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limited Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness Total _____ | GRAND TOTAL _____ |
| SKIN _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating Total _____ | | |



Financial Responsibility

Natural Healthcare that includes whole food supplementation, exercise and other remedies are not generally covered by third party payers (insurance companies). Revive Chiropractic provides its services directly to you, not to your insurance company. In certain cases, there may be the opportunity for reimbursement. Our financial policy is that fees are paid at the time of service and when products are provided they can be paid for by cash, check, or credit card. However, if applicable, we will provide you with the proper documentation for your reimbursement needs.

I have read and understood all the above information.

Patient Signature

Date

X-Ray Consent

____ Check here if you are pregnant or think you may be pregnant at this time.

I hereby give my consent to Revive Chiropractic and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.

I have read and understood all the above information.

Patient Signature

Date

Acknowledgement of Receipt of Privacy Practices

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature

Date

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to realign your spine. We do many gentle chiropractic techniques, though sometimes you may feel a “click” or “pop” and you may feel movement of the joint. The doctor may request x-rays to be taken if necessary, after reviewing your case. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscle soreness, fatigue, fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. We primarily do not use adjustments to the neck region that involve twisting that would cause this type of injury. The probability of adverse reaction due to ancillary procedures is also considered “rare”.

Other treatment options that could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

Informed Consent to Chiropractic Treatment

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my consent to treatment.

Signature

Date

Privacy Practices

We are very concerned with protecting your privacy. While the law requires us to provide you with a complete, detailed disclosure at your request, please understand that we will always respect the privacy of your health information.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization may need to use my name, address, phone number, e-mail, and clinical records to contact me with appointment reminders, information about treatment alternatives, newsletters, or other health related information that may be of interest to me. I consent to receive communications sent by or on behalf of Revive Chiropractic via regular mail, e-mail, telephone, or fax. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone. By signing this form, I am giving you authorization to contact me with these reminders and information and to leave messages on my answering machine or with individuals at my home or place of employment.

Name _____

Date _____