**New Patient Information** Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI: \_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #:\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_\_\_\_

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s DOB: \_\_\_\_/\_\_\_\_ /\_\_\_\_

Names and Ages of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find us? (Please circle one) Internet Insurance Promo/Event Facebook Friend or Family: (name of person)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Allergic To** | **Reaction** |
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 ***Please list any medication, food or environmental allergies:***

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| --- | --- | --- | --- |
| **Medication** | **Dosage** | **How often** | **Reason** |
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***Please list any medications or supplements you currently take and why:***

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| --- | --- |
| **Surgery** | **When** |
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***Please list any surgeries or traumas you’ve had:***

**** **Patient’s History**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Medical History- *Please check any issues experienced by you or your family members*

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| Self | Mom | Dad | GP’s |
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Alcohol…………Allergies………..Arthritis………...Blood Pressure…Cancer………….Cholesterol……..Chronic Fatigue..Colitis………….Convulsions……Depression……..Diabetes………..Drugs…………..Fibromyalgia…..Gastric/Reflux…Headaches……..Heart disease…..Hepatitis……….HIV/Aids………Immune System..  |

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| Self | Mom | Dad | GP’s |
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IBS……..………...Lung Disease…….Lupus…………….Mental Illness……Multiple Sclerosis..Musc.Dystrophy…Osteoporosis……..Rheumatic Fever…Scarlet Fever……..Seizures………….Shingles………….Skin Disorder…….Sleep Disorder…...Stroke…………….Thyroid Disease….Varicose Veins…..Weight Gain/Loss.. |

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|  | **EX. Lift Weights** | **3x week** |
|  | Driving Long Distance |  |
|   | Exercise  |  |
|   | Lift Weights |  |
|  | Play Sports |  |
|  | Sleep Comfortably |  |
|  | Sleep on Stomach |  |
|  | Talk on Phone |  |
|  | Travel |  |
|  | Yoga |  |

 **Patterns in your life**

**Consultation** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Present Condition** |
| *List conditions in order of concern and rate your level of pain, 10 being extreme*1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/102.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/103.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/104.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/105.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/10 |

**Current Symptoms** *Please check any of the following that apply to you:*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Knee Pain |  | Sinus Problems |  | Arm Pain |  | Muscle Spasm |  |
| Leg Cramps |  | Asthma |  | Circulatory Problems |  | Carpal Tunnel |  |
| Numbness in Toes |  | Allergies |  | Hands Cold |  | Pregnancy |  |
| Tingling in Legs |  | Weak Immune Syst |  | Mid Back Pain |  | Joints Swelling |  |
| Weakness in Legs |  | Indigestion |  | Numbness in Fingers |  | Sleep Problems |  |
| Sciatica Pain |  | Belching/Gas |  | Tingling in Arms |  | Stress |  |
| Lower Back Pain |  | Constipation |  | Shoulder Pain |  | Frequent Colds |  |
| Ringing in Ears |  | Vomitting |  | Upper Back Pain |  | Hives |  |
| Dizziness |  | Bladder Infection |  | Neck Pain |  | Fever |  |
| Poor Balance |  | Vertigo |  | Headache |  | Loss of Smell |  |

|  |
| --- |
| **Who have you seen for your symptoms and when? Date** |
| Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physical Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**** **Financial Policy**

We are pleased to accept your insurance assignment subject to verification of your coverage. We will file your claims as a courtesy to you. However, it must be fully understood that the contract is between you and your insurance company and **you are fully responsible for any amount not paid by your insurance.**

I accept assignment of benefits for medical payments to be made directly to Chiropractic Wellness Center.

I authorize the release of any medical information necessary in the processing of my insurance claims.

I agree that I will pay the percentage of charges not covered by my insurance company at the time of service as deductible, co-insurance, co-pays.

I agree that I will pay in full for charges of services rendered by Chiropractic Wellness Center for either self-pay accounts or services that will not be covered by my insurance company, at the time they are incurred and, if for any reason my insurance company does not cover charges within sixty days or a claim is denied, I will make payment arrangements immediately.

I agree that if my insurance company refuses to accept assignment of benefits or for some reason sends the payments to me, I will bring or send those payments to Chiropractic Wellness Center immediately.

I understand and agree that Chiropractic Wellness Center will not enter into any dispute with my insurance company regarding a claim and that this is my responsibility and obligation.

I agree that a copy of this document can be considered the same as an original when used for insurance billing purposes.

I understand that I may be charged $10 for missed appointments.

I certify that I have read and understand the Financial Policy of Chiropractic Wellness Center and agree it is true and accurate to the best of my knowledge. I authorize this office and its staff to examine and treat my condition as the doctors see medically necessary. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment unless prior arrangements have been made.

I agree with this statement of authorization

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chiropractic Informed Consent**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both the chiropractor and the patient to be working towards the same objective. Chiropractic has only one goal, to detect and reduce/correct misalignment. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, and therapeutic exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. Any increase in the current level of discomfort should be immediately reported to a staff member.

There are expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

**Adjustment:** Spinal manipulation is the specific application of forces to facilitate the body’s correction of misalignment to restore normal motion and position of individual vertebrae.

**Interferential current therapy:** Small electrical impulses used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural endorphins.

**Intersegmental traction therapy:** This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints it promotes increased mobility and blood flow that leads to faster healing.

**Therapeutic Exercise:** The entire body benefits from this therapy, by correcting muscular imbalances. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

We do not offer to diagnose or treat any disease or condition other than misalignment. If during the course of a chiropractic evaluation, 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 a health care provider specializing in that area.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**** **Cancellation Policy**

In our desire to be effective and fair to all of our clients and out of consideration to our doctor’s time, we have adopted the following policy:

***\*Anyone who misses their appointment without notifying the office prior to their scheduled time, will be considered a “no-show”.***

***A $10 fee will be due before you can be seen again.***

Thank you for understanding.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Photo Release**

Social media is a great way to spread the word about chiropractic care. Through photos and videos, we are able to share with others what exactly goes on here at Chiropractic Wellness Center.

Please know that only your first name will be used and we promise to only use “flattering” pictures.

If you are comfortable with us snapping photos of you occasionally, and sharing on our social media, please sign the statement below.

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission for Chiropractic Wellness Center to take pictures of my treatments and use on Chiropractic Wellness Center’s social media pages.*

Patient’s Signature: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Witnessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



 @CWCKCMO