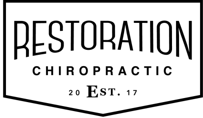


WELCOME TO

RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

GENERAL INFORMATION - Please print clearly. Information is confidential.

Patient First Name: ________________________ Last: ________________________ MI:__________

Date of Birth:____/____/____ Age:______ Sex: ☐Male ☐Female

Address:________________________________City:__________________ State:_____Zip:________

Occupation:______________________ Employer:_________________________

Phone (Cell): _________________ Phone (Work):_________________ Other:__________________

Email: ___________________________________ Are you: ☐ Married ☐Single ☐ Widowed ☐ Divorced

Spouse's Name __________________________Phone:________________ Number of Children_____

How did you hear about us? ☐ Online Search _______________ ☐ Referral _______________

☐ Event ______________ ☐ Social Media ______________ ☐Other _______________

Have you had previous Chiropractic care? ☐yes ☐no Chiropractor's Name: ______________________

What was the reason for your initial visit? ____

Were you given any type of treatment plan, home care stretching/strengthening program to assist your recovery? ☐yes ☐no If yes, please describe: ____

Did you follow it? ☐yes ☐no If not, why? ____

Why are you changing Chiropractors? ____

Who is your primary care physician?_________________________ Phone: _____________________

May we update your medical doctor regarding your treatment in our office? ☐yes ☐no

Date of last physical/exam? ____/____/____

Please list all Vitamins/Medications that you currently take: ____________________________________

____

Do you smoke or have you ever smoked in the past? ☐yes ☐no If yes, please describe _____________

____

Do you consume alcohol? ☐yes ☐no Do you consume caffeine? ☐yes ☐no Do you have a high stress level? ☐yes ☐no If yes, list reasons:____

Do you exercise? ☐yes ☐no If yes, how many times per week and what type? ___________________

____

WELCOME TO

RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

What is your **PRIMARY COMPLAINT** that brings you into our office? ______________________________

____

Date when symptom first appeared ____/____/____ What area of the body? _________________________

How Did it begin? ____

Type of Pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Other

Do you currently have Numbness or Tingling? ☐Yes ☐No

If so, where? ____

Does the Pain Radiate into: ☐Arm ☐Hand ☐Leg ☐Foot ☐Other________________ ☐Does not radiate

How often do you experience these symptoms?

☐ Constant 100% ☐ Frequent 75% ☐ Intermittent 50% ☐ Occasional 25% ☐ Rare 10%

Have you ever experienced the same or similar symptoms at any other time? ☐Yes ☐No

If so, when? ________________ What makes the symptoms worse? ______________________________

Are you taking any medication to currently relieve the symptoms of this problem? ☐Yes ☐No

If Yes, what: ☐Nerve Pills ☐Pain Pills ☐Muscle Relaxer ☐Blood Pressure ☐Other:_________________

Is there anything else that relieves your symptoms? ____

Do any family members suffer from the same complaint? ☐yes ☐no If so, who?___________________

Have you been to another doctor for this problem? ☐yes ☐no If so, who/where?___________________

Are your current symptoms accident related (auto, work or other)? ☐yes ☐no If yes, Please describe:

____

____

When did this accident occur? ☐Past Year ☐Past 5 Years ☐Over 5 Years

Please list all surgeries:____

____

Please list other injuries, accidents, falls, etc. that you have experienced other than your primary complaint: ____

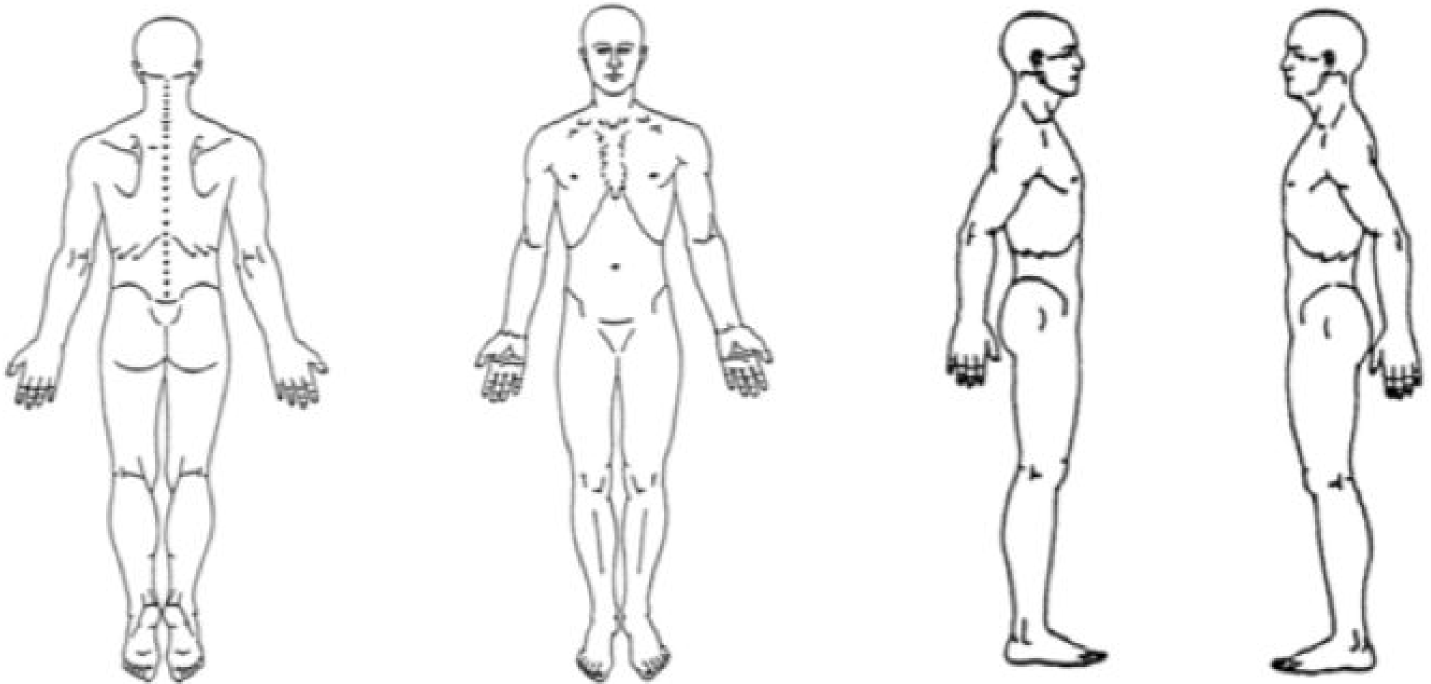
____

WELCOME TO
RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

Please <u>circle all areas of complaint</u> on the diagrams below and <u>label them</u> with the following indicators of pain:

A = ache, **D** = dull, **T** = tingling, **N** = numbness, **B** = burning, **S** = sharp or stabbing, **X** = other (please specify)



Please also label the number that best represents the intensity of your symptoms in each area of pain on a scale of 0-10 (0 being no symptoms, 10 being extreme)

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 EXTREME PAIN

WELCOME TO
RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

Health History - Please indicate any health conditions you *have* or *are currently* experiencing

☐ Fractured bones *(please describe)* ________
☐ Auto Accident(s)
☐0-1 yrs ago __________________

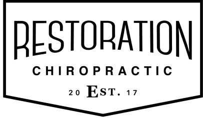
☐1-5 yrs ago ___________________
☐5+ yrs ago____________________
☐ Other Accidents, falls Describe __________
____
☐ Headaches:
☐Tension ☐Migraine ☐Dizziness
☐ Blurred or Double Vision
☐ Ringing in Ears
☐ Hearing Loss *(circle one)* R L Both
☐ Jaw Pain or Clicking *(circle one)* R L Both
☐ Neck Pain or Stiffness *(circle one)* R L Both
☐ Shoulder Pain *(circle one)* R L Both
☐ Upper Back Pain/Stiffness
☐ Mid Back Pain/Stiffness
☐ Lower Back Pain/Stiffness
☐ Pain with Cough or Sneeze
☐ Allergy, Sinus
☐ Hip Pain *(circle one)* R L Both
☐ Numbness/Tingling/Pain *(circle one)* R L Both
☐Arms ☐Hands ☐Fingers
☐ Numbness/Tingling/Pain *(circle one)* R L Both
☐ Buttocks ☐ Legs ☐ Feet ☐Toes
☐ Difficulty in Excessive Standing, Sitting, Riding,
Bending, Twisting, Lifting *(circle one)*
☐ Foot Trouble (circle one) R L Both
☐ Diabetes - Type 1 or Type 2 *(circle one)*
☐ Frequent Colds, Flu
☐ Convulsions, Epilepsy
☐ Trouble Sleeping

☐ Eating Disorders
☐ Under Stress *(please describe)* ___________
☐ Depression
☐ Irritability
☐ Trouble Concentrating
☐ ADD / ADHD
☐ Learning Disability *(please describe)* _______
☐ Skin Problems
☐ Mood Changes
☐ Anemia
☐ Bedwetting
☐ Ear Infections
☐ Chest Pain
☐ Asthma
☐ Heart Problems
☐ Stroke
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Varicose Veins
☐ Liver Problems
☐ Gall Bladder Problems
☐ Digestive Problems
☐ Ulcers
☐ Hemorrhoids
☐ Prostate Problems
☐ Impotence
☐ Kidney Trouble
☐ Menstrual Problems
☐ Pregnant *(currently)*
☐ Fertility Problems
☐ HIV, AIDS
☐ Cancer
☐ Arthritis
☐ Other: *(please describe)* ________________

Family History - Please list significant diseases/conditions experienced by immediate family members.

____

____



WELCOME TO

RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

TERMS OF ACCEPTANCE

It is important for each patient to understand both the objectives and the methods of chiropractic care. This will prevent any confusion or problems in the future. Please take some time to review the Terms below:

Adjustment: An adjustment is the specific application of forces and physiotherapy techniques to facilitate the reduction or correction of spinal misalignment, aka subluxation.
Health: A state of optimal function and not merely the absence of pain, symptoms or disease.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

Our office does not offer to diagnose or treat any diseases or condition other than Vertebral Subluxation. However, if during the course of a 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.

POLICIES

All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the front desk assistant.

I (please print)___________________________________ have read and fully understand the above **POLICIES** and **TERMS OF ACCEPTANCE**, and hereby grant permission to receive chiropractic services.

Patient Signature: _____________________________________ Date: _____________

Please fill out the Pregnancy Release below:

☐__________ **(initials required)** N/A - I am male

☐__________ **(initials required)** N/A - I am currently pregnant

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation and all necessary procedures for care. I have been advised that x-ray can be hazardous to an unborn child. Date of Last Menstrual Cycle _______________

Patient Signature: _____________________________________ Date: _____________

WELCOME TO

RESTORATION CHIROPRACTIC

NEW PATIENT FORM (ADULT)

INFORMED CONSENT TO TREAT & AUTHORIZATION OF CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as backup for Restoration Chiropractic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there may be other treatment options available for my condition besides chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms.

I hereby authorize the Doctor(s) and staff members of Restoration Chiropractic to work with my condition through the use of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, and any supportive therapies, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor’s Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor’s Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

I (please print)___________________________________ have read and fully understand and agree to both the above **INFORMED CONSENT TO TREAT & AUTHORIZATION OF CARE.**

Patient Signature: _____________________________________ **Date**: _____________