

Achieving Health Clinic

General New Patient Information

Patient _____

Cell# _____ Home# _____

Address _____

City _____ ST _____ Zip _____

E-Mail (please print) _____

For appointment reminders do you prefer a: Text or Phone Call?

Date of Birth _____ Age _____

Married _____ Single _____

Children _____ How Many _____

Employer _____

Occupation _____

How Did you hear about us? _____

Flex spending may cover services your insurance does not would you like more information about this? Yes _____ No _____

Do You Have Health Insurance? Yes _____ No _____ SS# _____

If yes, PLEASE give your Insurance Card and Driver's License to our Chiropractic Assistant

Payment Is Due Upon Services Rendered

X-RAYS

Please be as accurate as possible.

Chief Health Complaint _____

Other Complaints _____

Is This Condition Job Related Auto Accident Home Injury Fall Other

List any Accidents or Falls Along With Dates in Past 5 Years _____

Rate Your Pain Today (no pain) 1—2—3—4—5—6—7—8—9—10 (severe pain)

Rate Your Pain at its Worst (no pain) 1—2—3—4—5—6—7—8—9—10 (severe Pain)

Have You Ever Experienced This Condition Before Yes No If so, When _____

Have You Seen Anyone For This Condition Before Yes No Who _____

Diagnosis _____

Treatment _____

Which position do you typically sleep in? _____

Have You Seen A Chiropractor Before? Yes No

If yes when was your last chiropractic visit? _____

****Any Patient receiving Massage Therapy in the office is required to give a 24 hour cancellation notice, for any scheduled massage appointment. If a 24 hour notice is not given, we reserve the right to charge a \$30 fee for the missed appointment, which will be due before the next massage is received.**** Please initial below that you have read

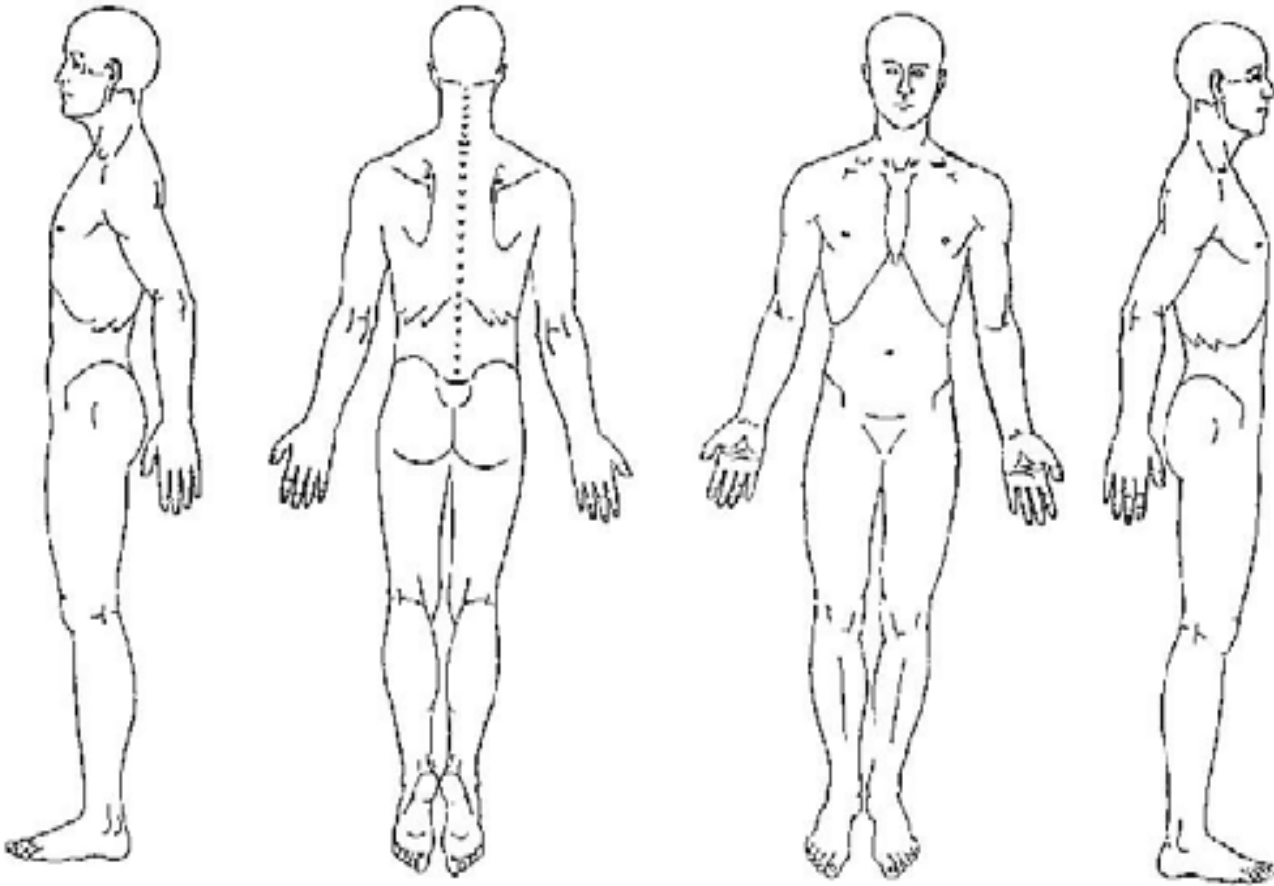
Initials _____

Left

Back

Front

Right



On The Diagram Above Please Indicate Where and the Type of Pain You are Experiencing

X—Sharp Pain N—Numbing/Tingling D—Dull Pain A—Aching R---Radiating

BELOW IS OFFICE USE ONLY

1.		2.	
O-	Pain#	O-	Pain#
Grad-		Grad-	
Better-		Better-	
Worse-		Worse-	
Time-		Time-	
Describe-		Describe-	
Site-		Site-	
D Activity-		D Activity-	

Medical History

Please Check Any of the Following You Have Had or Currently Have

Musculo-Skeletal

- Neck Pain/Stiffness
- Mid-Back Pain/Stiffness
- Low Back Pain/Stiffness
- Jaw Pain or click (TMJ)
- Joint Pain/Stiffness
- Difficulty in Excessive Standing, Sitting, Riding, Bending, Lifting, Twisting
- Shoulder Pain
- Hip Pain
- Muscle Weakness
- Vertebral Disc Rupture/Herniation Levels _____
- Arthritis
- Osteoporosis

Nervous System

- Numbness/Tingling Pain in Buttocks, Legs, Feet, Toes
- Trouble Sleeping
- Trouble Concentrating
- Under Stress
- Tingling Upper Extremities
- Seizures/Convulsions
- Dizziness
- Fainting

Family History

The following members have a same or similar problem as I do

- Mother
- Father
- Brother
- Sister
- Child
- Spouse

Genito-Urinary

- Bladder Problems
- Kidney Problems

Cardiovascular

- Stroke
- Chest Pain
- History of High Blood Pressure
- Heart Problems
- Arteriosclerosis
- Thrombosis/Phlebitis
- Varicose Veins

Pulmonary System

- Asthma
- Chronic Obstructive Pulmonary Disease
- Chronic Bronchitis

Ears, Eyes, Nose, Throat

- Sore Throat
- Ear Aches/Infections
- Allergies/Sinus Problems
- Headaches

Male/Female

- Prostate
- Menstrual Cramps
- Breast Pain/Lumps

Gastro-Intestinal

- Frequent Nausea
- Liver Problems
- Gall Bladder Problems
- Digestive Problems
- Heart Burn
- Constipation
- Vomiting of Blood
- Hernia and Type

Others

- Autoimmune Disorder
- Cancer
- Diabetes
- Fibromyalgia

Please List any Surgeries you have had along with dates _____

List Anything you are Allergic to _____

Do You Take Supplements or Vitamins Yes No If so, What _____

Do You Regularly Receive a Massage For Stress Relief or Rehabilitation? Yes No

If Determined That Massage Therapy Would Help Assist in Correcting Your Problem Would You Like more Information? Yes No

Do you have a preference in therapist? Male Female No preference

Do You Exercise Yes No If so, How much _____ Hours/Week

Are You a Member of a Gym or Health Club Yes No If so, Where _____

Are You Dieting If so, Since When ___/___/___

Do You Smoke Yes No If so, How much _____ Packs/Week

Are You Wearing Shoe Lifts Arch Supports Inner Soles

For Women: Are You Taking Birth Control Yes No

Are You Pregnant Yes No

Are You Currently Nursing Yes No If so, How many Weeks _____

By my signature on this form, I do hereby state that, to the best of my knowledge, I am not PREGNANT, NEITHER suspected nor confirmed at this particular time.

Patient's signature: _____

Achieving Health Chiropractic

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Achieving Health Clinic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent by email or asking for one at the time of my next appointment.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases the following may occur but not limited to fractures, disc injuries, strokes, dislocations and sprains. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority