



WELCOME FORM

We are so glad that you are here today. If you have any questions concerning our policies, forms or procedures, just ask. It is our pleasure to help you.

OUR PRIVACY PRACTICES

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed as well as how you may have access to the information.

WE MAY SHARE YOUR HEALTH INFORMATION TO:

- Treat you
- Discuss your case with family
- Collect Payment
- Do research
- Run our office
- Include you in care classes
- Inform you about other services
- Thank you for referring other patients

WE MAY USE YOUR HEALTH INFORMATION FOR:

- Health and safety reasons
- Reporting worker's compensation
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings

YOU HAVE THE RIGHT TO:

- Request a copy of your health record
- Request confidential communications
- Request a list of whom we share your health information with
- Amend your protected health information
- Ask us to limit the information we share
- Advise management if you believe your privacy rights have been violated

These privacy practices are effective as of January 1, 2011.

CONSULTATION & EXAM

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

REPORT OF FINDINGS

Patients who are examined will receive a report of our findings from the recorded history, consultation and examination.

If we believe we can help, we will accept your case at this time. If we believe you will not respond to our care, we will not accept your case and may refer you to another provider.

TREATMENT PLAN

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

Date

Print Name-patient or guardian

Signature-patient or guardian

THE NATURE OF A CHIROPRACTIC ADJUSTMENT

The chiropractic adjustment involves the use of hands or a mechanical adjusting device contacting the joints of your body in such a way as to bring motion to your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel or sense movement.

THE MATERIAL RISKS INHERENT IN A CHIROPRACTIC ADJUSTMENT

As with any health care procedure, there are certain side effects or complications which may arise during a chiropractic adjustment. Those complications can include: a fracture, dislocation, disc injury, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strain or separation. Some patients will feel stiffness or soreness following the first few days of treatment.

THE PROBABILITY OF THOSE RISKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone; therefore, you will receive an evaluation checking for this during your history and physical examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

ANCILLARY TREATMENTS AND RISKS

In addition to chiropractic adjustments, we may consider using additional treatments. These treatments may involve the following risks:

- Cyrotherapy: May cause skin reactions
- Heat: May cause 1st and 2nd degree burns, hemorrhage
- Low Tech Rehab: May cause aggravation of present condition, blood pressure changes, increased heart rate
- Graston (used to “break up” or “soften” scar tissue): May cause local discomfort, skin reddening, superficial tissue bruising, post treatment soreness

Please check if any of the following apply to you:

- | | |
|--|--|
| <input type="radio"/> Your blood clots slowly | <input type="radio"/> Bruise easily |
| <input type="radio"/> Bleed for a prolonged time | <input type="radio"/> Ever had inflamed veins or blood clots |
| <input type="radio"/> Have diabetes, kidney disease or infection | <input type="radio"/> Have surgical implants |
| <input type="radio"/> Have uncontrolled high blood pressure | <input type="radio"/> Regularly take blood thinners, aspirins, cortisone |

OTHER TREATMENT OPTIONS

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization with traction
- Surgery

THE RISKS AND DANGERS ATTENDANT TO CHOOSING TO REMAIN UNTREATED

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

CONDITION OF PATIENT AT TIME OF CONSENT PROCESS

Based on our personal observation and direct conversation with the patient, we conclude that throughout the consent process (s)he was:

- Appears oriented as to time and place
- Appears coherent and lucid
- Patient denies receiving any medications that impairs judgement
- Patient takes medications but judgement is unimpaired
- Able to understand the language used
- Assisted in understanding by use of an interpreter
(Interpreter’s name: _____)
- Assisted in consent process by family members/staff members

Name

Relationship

SIGN ONLY IF YOU HAVE READ AND UNDERSTOOD ALL OF THE ABOVE

I have read _____
Patient initials

OR

I have had read to me _____
Patient initials

The above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interests (or the minor patient's best interest) to undergo treatment recommended. Having been informed of the risks, I hereby give my consent to New Directions Chiropractic to perform the treatment and acknowledge that no guarantee of assurance as to the results that may be obtained from this treatment has been given to me.

We certify that the above accurately describes the consent process in the case.

Date

Print Name-patient or guardian

Signature-patient or guardian



NEW PATIENT FORM

PERSONAL INFO

FIRST NAME		LAST NAME	
DATE OF BIRTH	AGE	SEX <input type="radio"/> M <input type="radio"/> F	
ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS			
TELEPHONE		ALT. PHONE	
WHICH COMMUNICATION DO YOU PREFER FOR APPOINTMENT REMINDERS? <input type="radio"/> TELEPHONE CALL <input type="radio"/> TEXT MESSAGE <input type="radio"/> E-MAIL <input type="radio"/> ANY IS ACCEPTABLE			
OCCUPATION		EMPLOYER	
MARITAL STATUS <input type="radio"/> SINGLE <input type="radio"/> MARRIED <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED		# OF CHILDREN	
SPOUSE/EMERGENCY CONTACT		PHONE	

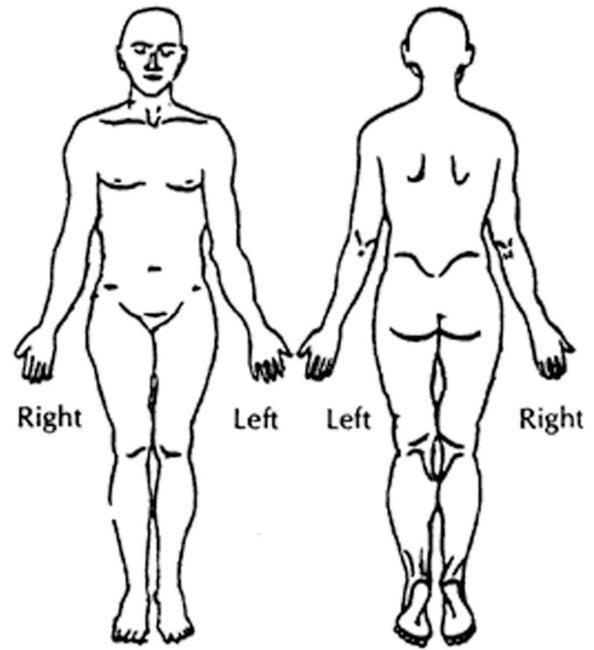
CURRENT COMPLAINTS

REASON FOR YOUR VISIT TODAY	
HOW DOES THIS AFFECT YOUR DAILY ACTIVITIES?	
DATE IF INJURY	DATE SYMPTOMS APPEARED
HAVE YOU EVER HAD THE SAME CONDITION? <input type="radio"/> N <input type="radio"/> Y IF YES, WHEN?	
LIST OTHER PRACTITIONERS SEEN FOR THIS COMPLAINT	
HAVE YOU EVER BEEN UNDER CHIROPRACTIC CARE? <input type="radio"/> N <input type="radio"/> Y IF YES, WHEN?	
IF YOU HAVE PAIN, IS IT? <input type="radio"/> SHARP <input type="radio"/> DULL <input type="radio"/> CONSTANT <input type="radio"/> INTERMITTENT <input type="radio"/> TRAVELING <input type="radio"/> RADIATING <input type="radio"/> MILD <input type="radio"/> MODERATE <input type="radio"/> SEVERE <input type="radio"/> INTOLERABLE	
WHAT MAKES IT BETTER?	WHAT MAKES IT WORSE?

PLEASE INDICATE THE TYPE AND LOCATION OF THE SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

- A=ACHE
- B=BURNING
- N=NUMBNESS
- P=PINS AND NEEDLES
- S=STABBING
- T=TINGLING
- O=OTHER

IF OTHER, WHAT DOES IT FEEL LIKE?



MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR? <input type="radio"/> N <input type="radio"/> Y IF YES, PLEASE DESCRIBE	
DATE OF LAST PHYSICAL EXAM	HAVE YOU HAD X-RAYS TAKEN? <input type="radio"/> N <input type="radio"/> Y
ARE YOU OR COULD YOU BE PREGNANT? <input type="radio"/> N <input type="radio"/> Y IF YES, PLEASE ANSWER BELOW	
FOR PREGNANT PATIENTS ONLY # OF WEEKS	ESTIMATED DUE DATE
BIRTH PROVIDER	
GOALS FOR LABOR/DELIVERY (LOCATION, WHO WILL BE THERE, ATMOSPHERE, ETC.)	
COMPLICATIONS/SYMPTOMS RELATED TO THIS PREGNANCY	
PREVIOUS PREGNANCY/LABOR/DELIVERY COMPLICATIONS	
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (INCLUDE DOSAGE & FREQUENCY)	
WHAT VITAMINS, MINERALS OR HERBS ARE YOU CURRENTLY TAKING? (DOSAGE & FREQUENCY)	
HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING	IF YES, PLEASE DESCRIBE
<ul style="list-style-type: none"> <input type="radio"/> HEADACHES/MIGRANES <input type="radio"/> PINS/NEEDLES IN (CIRCLE) LEGS FEET ARMS HANDS <input type="radio"/> NUMBNESS <input type="radio"/> LOSS OF SMELL OR TASTE <input type="radio"/> BACK STIFFNESS OR PAIN <input type="radio"/> LOSS OF BALANCE <input type="radio"/> ALLERGIES/SINUS PROBLEMS <input type="radio"/> ANXIETY <input type="radio"/> DEPRESSION <input type="radio"/> IRRITABILITY/MOOD SWINGS <input type="radio"/> ARTHRITIS 	

(CONT) HAVE YOU EVER SUFFERED...	IF YES, PLEASE DESCRIBE
<ul style="list-style-type: none"> <input type="radio"/> SEIZURES <input type="radio"/> STOMACH UPSET/HEARBURN/REFLUX <input type="radio"/> FATIGUE <input type="radio"/> NECK STIFFNESS/PAIN <input type="radio"/> BROKEN BONES <input type="radio"/> COLD HANDS/FEET <input type="radio"/> DIARRHEA/CONSTIPATION/GAS <input type="radio"/> FOOT PROBLEMS <input type="radio"/> BREATHING PROBLEMS/ASTHMA <input type="radio"/> HOT FLASHES <input type="radio"/> COLD SWEATS <input type="radio"/> HEPATITIS A B C <input type="radio"/> TUBERCULOSIS <input type="radio"/> HIGH/LOW BLOOD PRESSURE <input type="radio"/> HIGH CHOLESTEROL <input type="radio"/> VD/HIV/AIDS <input type="radio"/> PMS OR MENOPAUSE <input type="radio"/> DIABETES <input type="radio"/> KIDNEY PROBLEMS <input type="radio"/> HEART DISEASE <input type="radio"/> SKIN DISORDER <input type="radio"/> THYROID DISORDER <input type="radio"/> ALCOHOL OR DRUG DEPENDENCY <input type="radio"/> CANCER <input type="radio"/> LOSS OF MEMORY <input type="radio"/> LOSS OF BALANCE <input type="radio"/> LOSS OF SMELL <input type="radio"/> LOSS OF TASTE <input type="radio"/> ULCERS <input type="radio"/> VARICOSE VEINS <input type="radio"/> SCIATICA <input type="radio"/> NOSE BLEEDS <input type="radio"/> SWOLLEN JOINTS <input type="radio"/> POOR POSTURE 	

FAMILY HISTORY

PLEASE LIST PRESENT AND PAST HEALTH CONDITIONS SUFFERED BY FAMILY MEMBER

HABITS

	NONE	LIGHT	MODERATE	HEAVY
ALCOHOL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CAFFEINE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TOBACCO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DRUGS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXERCISE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WATER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FRUITS/VEGGIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SLEEP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>