New Patient History

Name_____ Male / Female DOB _____/_____/_____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email: _____ Marital Status S M D W Spouse Name _____ No. of Kids _____

Occupation _____ Years at job _____ Employer _____

How would you like your appointment reminders? Email ◯ Text ◯ (select one) If text, who is your carrier? _____

How far in advance would you like your reminder? 30min ◯ 45min ◉ 1 hour ◯ 2 hours ◯ 4 hours ◯ 1 day ◯ 2 days ◯ 1 week ◯

Referred by: (Please select all that apply) ☐ Internet ☐ Radio Ad ☐ Presentation / Screening ☐ Location/ Street Sign

☐ Friend _____ ☐ Other_____

Are you at this wellness center because of a work injury? _____ If yes, what was the date of the injury? _____

Are you at this wellness center because of an auto accident? _____ If yes, what was the date of the injury? _____

Emergency Contact Name/Relationship:_____ Telephone:_____

Accident History: Please list previous injuries and accidents from most severe to least severe.

1. _____ What year? _____
2. _____ What year? _____
3. _____ What year? _____
4. _____ What year? _____

Additional: _____

Surgical History: Please list all surgeries from most severe to least severe

1. _____ What year? _____
2. _____ What year? _____
3. _____ What year? _____
4. _____ What year? _____

Additional: _____

Pharmaceutical History: Please List all medications you are taking, how long you have been taking them, and what they are for.

1. _____ How Long: _____ Why: _____
2. _____ How Long: _____ Why: _____
3. _____ How Long: _____ Why: _____
4. _____ How Long: _____ Why: _____

Additional: _____

Past History: Previous injuries, illness, and past hospitalizations (Please list from most to least severe)

1. _____ What year? _____
2. _____ What year? _____
3. _____ What year? _____
4. _____ What year? _____

Additional: _____

Family History: Please list immediate family diseases and whom it afflicted. Ex: Cancer-mother, Diabetes- father, Cardiovascular-brother, etc: _____

_____

Allergy History: Do you have any allergies? _____

_____

Patient, Parent, or Legal Guardian Signature: _____ Date: _____

Initial Exam & Progress Exam Intake Questionnaire

Name_____ DOB _____/_____/_____

Problem # 1:
Where is your first area of discomfort, pain, dysfunction?_____ ◉ Left ○ Right ○ Middle (select one)

Please describe the problem. (ex; sharp, dull, achy, stabbing, etc.) _____

Does the problem cause pain to radiate or refer anywhere?_____

On a scale of 1-10 with 1 being the best and 10 being the worst, how would you rate your problem: (please fill in a number)
Problem #1: Currently:_____ At it's worst:_____ At it's best:_____ On Average:_____

How often do you have the problem? (circle one) 0-25% of the time, 26-50% of the time, 51-75% of the time, 76-100% of the time

When did the problem begin? _____ days _____ months _____ years ago? How? _____

Since the problem began, how would you describe the symptom: getting better getting worse staying the same

What actions aggravate problem #1:_____ When is it at its worst?

What actions relieve problem #1: _____ ○ Morning ○ Afternoon ○ Evening

Problem # 2:
Where is your second area of discomfort, pain, dysfunction?_____ ○ Left ○ Right ○ Middle (circle one)

Please describe the problem. (ex; sharp, dull, achy, stabbing, etc.) _____

Does the problem cause pain to radiate or refer anywhere?_____

On a scale of 1-10 with 1 being the best and 10 being the worst, how would you rate your problem: (please fill in a number)
Problem #1: Currently:_____ At it's worst:_____ At it's best:_____ On Average:_____

How often do you have the problem? (select one) ○ 0-25% of the time, ○ 26-50% of the time, ○ 51-75% of the time, ○ 76-100% of the time

When did the problem begin? _____ days _____ months _____ years ago? How? _____

Since the problem began, how would you describe the symptom: getting better ○ getting worse ○ staying the same ○

What actions aggravate problem #2:_____ When is it at its worst?

What actions relieve problem #2: _____ ○ Morning ○ Afternoon ○ Evening

Additional Problems:
Describe in the same manner as above the terms above (please write on the back if necessary): _____

ADL's and Goals:
Because of your symptoms or problems, what things are you unable or less able to do on a daily basis. (Examples: Pick up children; play a sport; sit comfortably at work; exercise; do laundry; think clearly without headaches; communicate with a spouse; etc.)

Are you currently seeing any other physicians or therapists for these conditions? Yes ○ No ○
If yes: Who? Where? and When? _____

Please list any changes to your medications: _____

Is there any chance that you might be pregnant: _____ Date of LMP: _____

Patient, Parent, or Legal Guardian Signature: _____ Date:_____

Health & Wellness Questionnaire

Name_____ DOB _____/_____/_____

Have you ever been adjusted by a Chiropractor? Yes ○ No ○ Where, and When? _____

Was the visit for symptom (relief) care or wellness care and lifestyle improvement? _____

Health:

How would you describe your general state of health? Please select: Poor ○ Good ○ Great ○
If not great, why not? _____

Which describes your digestion? Please select: Poor ○ Good ○ Great ○
Please describe: _____

Which describes your sleep patterns? Please select: Poor ○ Good ○ Great ○
How many hours do you sleep each night? _____

Which describes your energy patterns? Please select: Poor ○ Good ○ Great ○
What time of day do you have the most energy? _____

Have you had any weight changes? Please describe: _____

Have you had any mood changes? Please describe: _____

Do you have any new allergies? Please describe: _____

Habits:

Do you take vitamins and mineral supplements? Which ones? _____

Do you supplement fish and/or omega 3's? Which ones? _____

How often do you eat fruits and vegetables? 1-2 times per day ○ 3-4 times per day ○ 5-6 times per day ○ Every Day ○

Are they organic? All ○ Some ○ None ○

How comfortable are you eating genetically modified foods? _____

Do you use alcohol? How often? _____

Do you use tobacco? How often? _____

ADL's and Goals:

Because of your symptoms or problems, what things are you unable or less able to do on a daily basis. (Examples: Pick up children; play a sport; sit comfortably at work; exercise; do laundry; think clearly without headaches; communicate with a spouse; etc.)

_____
_____
_____
_____

What are your top 3 health goals for this / next year?

1. _____
2. _____
3. _____

Patient, Parent, or Legal Guardian Signature: _____ Date: _____

Financial Terms & Policies

I agree that my health is most important to me and I further agree to take responsibility to understand what treatment is rendered, why it is being rendered and to understand the cost and necessity of the treatment. Regardless of insurance assistance, I agree to pay my patient responsibility at the time services are rendered unless otherwise arranged with my primary provider. We reserve the right to change our fees as necessary to cover increased costs of care.

I understand that I am financially responsible for and agree to pay all charges whether or not paid by insurance, attorney or any other third party. I hereby authorize the provider to release all information necessary to secure the payment of benefits.

Insurance Policies

I authorize the use of the signature below on all insurance submissions. I understand that Devine staff will assist in the verification of my insurance benefits and it is not a guarantee of payment. I also understand my relationship is with my insurance company and that Devine offers assistance to help me receive benefits but not responsible for the result of payment. If for some reason insurance cannot be verified at the time of visit, I agree to pay an $80 minimum deposit for visit.

Patient/ Parent (if under 18)/
Legal Guardian Signature _____ Date _____

HIPAA Consent

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means or communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided and a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and that I have the option of viewing a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I request the following restriction to the use or disclosure of my health information: _____

I consent to the use and disclosure of my health information for treatment, payment and health care operations as described in this notice of consent.

Patient/ Parent (if under 18)/
Legal Guardian Signature _____ Effective Date _____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Patient/ Parent (if under 18)/ Legal Guardian Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that I have been advised that x-ray can be hazardous to an unborn child. I understand that the doctor and his/her associates have permission to perform or request an x-ray evaluation and that it is my responsibility to inform them if I am pregnant or suspect that I may be pregnant. Please choose from the following:

- ☐ I am Pregnant. Expected Due Date:_____
- ☐ I am not Pregnant. Date of last Menstrual cycle:_____

_____	_____
Patient/ Parent (if under 18)/ Legal Guardian Signature	Date