New Ulm Chiropractic
Potential Realized.

Date: _____
Patient #: _____

Name: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Ph: _____ Work Ph: _____ Cell Ph: _____
E-mail Address: _____
DOB: _____ Marital Status: M W D S Spouse's name: _____
Children's Name & Ages: _____
Occupation: _____ Employer: _____
Most patients are referred to our office by a caring family member or friend. Who may we thank for referring you to our office? _____
Research shows that a spine should be checked regularly. Have you seen a chiropractor in the past? Yes / No
How regularly were you getting adjusted by your previous chiropractor? _____
Who is your medical doctor(s)? _____ Clinic name and city: _____

Insurance Information

If you are insured and wish for us to assist you in submitting claims, please provide us with your insurance card so that we may verify how your provider participates with chiropractic care in this office.

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Briefly describe the chief area of complaint(s), including the effect that it has had on your life:

_____

_____

_____

Since the problem started, is it: Getting better The same Getting worse
Does it interfere with: Work Sleep Walking Sitting Hobbies Leisure Family time
When did it first appear? _____ Have you experienced it in the past? Yes / No
Has anyone in your family experienced similar problems? Yes / No If so, who? _____
Doctors seen for this problem: Chiropractor Yes / No Medical Doctor Yes / No Other: _____
Do you suffer from any condition other than that which you are now consulting us? Yes / No Please explain:

_____

_____

BODY SIGNALS

Please circle **ALL** symptoms (body signals) you have had <u>in the past year</u>, even if they do not seem related to your current problem:

Headaches	Loss of smell	Fainting	Neck pain	Cold sweats
Pins and needles in arms	Pins and needles in legs	Back pain	Loss of balance	Mood swings
Dizziness	Buzzing in the ears	Ringing in the ears	Nervousness	Light bothers eyes
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset	Heartburn
Fatigue	Depression	Irritability	Tension	Hot flashes
Sleeping problems	Stiff neck	Fever	Ulcers	Cold hands & feet
Diarrhea	Menstrual pain	Problems urinating	Menstrual irregularity	Constipation

Stress can cause or accelerate spinal damage. Rate your level of stress over the past 90 days: < 1 2 3 4 5 6 7 8 9 10 >
Poor posture leads to poor health and often indicates a spinal condition.

How would you rate your posture? Poor < 1 2 3 4 5 6 7 8 9 10 > Excellent

Prescription medication may cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal. What medications are you currently taking? _____

_____

Your nervous system consists of your **brain, spinal cord, and nerves**. Have you ever seen a doctor (or been prescribed medication) specifically for any issues related to your nervous system? _____

Which vitamins or supplements are you currently taking? _____

What do you like to do for fun?! _____

_____

What are your *overall* health and wellness goals?

_____

_____

_____

_____

PAST MEDICAL HISTORY (Check ones that you have had in the past)

___ Hay fever	___ Mumps	___ Rheumatic fever	___ Allergies	___ Sexual problems
___ Cancer	___ Tumor	___ Blood disease	___ Leukemia	___ Heart trouble
___ Depression	___ Phlebitis	___ Hypertension	___ Stroke	___ Mental illness
___ Jaundice	___ Polio	___ Skin trouble	___ Gallstones	___ Liver trouble
___ Hepatitis	___ Parasites	___ Epilepsy	___ Paralysis	___ Prostate problem
___ Alcoholism	___ Dysentery	___ Varicose veins	___ Diabetes	___ Gout
___ Syphilis	___ Migraine	___ Hemorrhoids	___ Nervous breakdown	___ Gonorrhea
___ Ulcers	___ Angina	___ Bladder trouble	___ Kidney stones	___ Kidney infections

For women only: Is there a chance that you could be pregnant? Yes / No

FAMILY HISTORY (If mom dealt with it, put an M. If dad, put a D. If both, put a B.)

___ High blood pressure	___ Thyroid disease	___ Asthma
___ Diabetes	___ Seizures/convulsions	___ Allergies
___ HIV positive	___ Emphysema	___ Cancer
___ Arthritis/rheumatoid	___ Mental illness	___ Digestive problems
___ Heart attack	___ Circulation problem	___ Ulcers
___ Kidney disease	___ Stroke (include age)	___ Other: _____

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of improving their health and working toward their health goals listed above. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we invite you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your health records, please inform our front desk. Thank you!

Patient signature: _____ Date: _____