NEW PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and insurance cards if applicable

Name: ____ Gender: M F Birth Date: ____/____/______ Age: ___
Address: ______________________________________ City: ______________State: _________ Zip: _______
Social Sec #: ____-____-______ Email: ____________________________@______________.__________
Home Phone: _____-____-______ Cell: ___-____-_____ May we use your first name/picture for promotions? Y N
May we send you newsletters & emails? Y N
Text messages Y N Carrier?__________________

Marital Status: S M D W # of Children_______ Ages of Children ________________________________

Work Status: Fulltime Part Time Retired Disabled Unemployed

Primary Care Physician: ___________________ Phone # ____-____-______ May we contact? Y N
Who may we thank for referring you? ____

Females: Last menstrual period: _______ Pregnant? Y N Nursing? Y N

Employer: _________________________ Occupation: __________________ Work Phone:____-____-______
Employer Address: _______________________________ City: __________________ Zip: _____________
HR Rep: _____________________ May we contact? Y N

Name of spouse, parent or guardian: _____________________ Birthdate: ___/___/_____ SS#:___-___-_____
Spouse/Parent Employer: ________________________ Occupation: __________________________________

Emergency Contact: ______________________ Phone: ____-____-______ Relation: ____________________

Who is responsible for your bill? You, and: Spouse Workers Comp. Auto Ins Medicare Personal Insurance
Insured persons name: ________________ Date of Birth: ___/___/_____ Relation: ______________________

Do you wear a shoe lift? Y N Prescribed by whom? ____
Previous Chiropractic Care? Y N Doctors name and last visit: ______________________________________

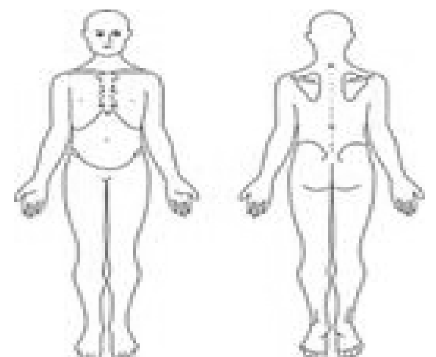
Health concerns/problems/areas of pain:
1. ____ 2. ____
3. ____ 4. ____

What type of treatment are you looking for?
[] I am looking for the most minimal amount of care to "patch up the symptoms" of my problem
[] I am looking to resolve my symptoms and then go on to fix the cause of my problem
[] I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

Is this condition [] Job related [] Auto Accident [] Home injury [] Fall [] Other Accident: ________________
Have you made a report of this accident to your employer/ auto insurance ______________________________

Has another doctor treated you for this condition? Y N
Whom? MD DO DC DDS Other________

Please outline on the diagram the area of your discomfort



Place an "X" on the line showing the degree of your discomfort:

No Symptoms | Extreme Symptoms

I--I

Please circle all that apply- (P= Past issue, C= Current issue)

P C headache	*P C* high blood pressure	*P C* tingling in feet	*P C* facial pain
P C walking problems	*P C* eye pain	*P C* abdominal pain	*P C* sore muscles
P C nausea/ vomiting	*P C* weak muscles	*P C* dizziness	*P C* poor appetite
P C earache	*P C* fullness of bladder	*P C* shakiness	*P C* forgetfulness
P C sweating	*P C* confusion	*P C* frequent urination	*P C* insomnia
P C constipation	*P C* fainting	*P C* teeth grinding	*P C* hemorrhoids
P C dry mouth	*P C* decreased sex drive	*P C* irritability	*P C* excessive thirst
P C impatience	*P C* unpleasant taste	*P C* elbow/hand pain	*P C* fatigue
P C tingling in hands	*P C* loss of control	*P C* sore throat	*P C* clammy hands
P C low back pain	*P C* swallowing pain	*P C* hip pain	*P C* unsteady voice
P C shoulder pain	*P C* poor circulation	*P C* persistent coughing	*P C* swollen joints
P C joint stiffness	*P C* slow heart rate	*P C* swollen ankles	*P C* rapid heart rate
P C low blood pressure	*P C* blurred vision	*P C* paralysis	*P C* sinusitis
P C urination difficulty	*P C* convulsions	*P C* menstrual irregularities	*P C* neck pain
P C lump in throat	*P C* knee pain	*P C* chest pressure	*P C* ankle/foot pain
P C heart problems	*P C* lung problems	*P C* stroke	*P C* breast pain/lump
P C prostate/sexual dysfunction			

Allergies/Sensitivities: Please circle/list all allergies

Food: Wheat Soy Seafood Gluten Peanuts Fruits Other: ________________________________

Meds: Penicillin Sulfa Drugs Iodine Insulin Antibiotics Other: ___________________________

Seasonal/Other: Pollen Dust Hay Mold Chemicals Smoke Animals Insects Other: _____________

Current Medications: Please list below or allow us to copy your prescription list

____

____

____

Vitamins: Do you take any vitamins/supplements? Y N Please list: ________________________________

____

Surgical Procedures: List all and approximate date ____

____

Habits:	Heavy	Moderate	Light	None
Alcohol	[]	[]	[]	[]
Coffee	[]	[]	[]	[]
Soda	[]	[]	[]	[]
Tobacco	[]	[]	[]	[]
Drugs	[]	[]	[]	[]
Stress Level	[]	[]	[]	[]

<u>Exercise</u>: [] 5-7x/week [] 3-5x/week []1-3x/week [] None

<u>Sleep</u>: [] 8+ Hours [] 6-7hours [] 5-6 hours [] less than 5

Meals: [] 5+/day [] 4/day [] 3/day [] 2/day []1/day

Water: [] 64+ oz [] 32-64 oz [] 16-32 oz [] 8 oz or less

What activities aggravate your symptoms? Sitting Standing Riding Walking Bending Lifting

Other: ____

What, if anything, relieves your symptoms? ____

____

Work Activities: Heavy Labor - Light Labor - Mostly Sitting - Mostly Standing - Moving/Walking - Driving

Family History: Identify any conditions you or any of your family have now or had in the past:
F=Family, P=Personal

_______Alcoholism	_______ Eczema	_______ Miscarriage(s)	_______Tumor
_______Anemia	_______ Emphysema	_______ Mumps	_______ Ulcer
_______Cancer	_______ Epilepsy	_______ Pleurisy	_______Other: ___________
_______Cold Sores	_______ Goiter	_______Pneumonia	______Deep Vein Thrombosis
_______Gout	_______ Polio	_______ Detached Retina	_______ Heart Disease
_______Diabetes	_______ HIV/AIDS	_______ Stroke	_______Rheumatic Fever

INFORMATION AND RESPONSIBILITES
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that McAvoy Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to McAvoy Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all fees for professional services rendered to me will be immediately due and payable. I also understand that occasionally insurance companies will send the checks to me; and I should contact McAvoy Chiropractic before cashing them to see if they represent my bill with McAvoy Chiropractic. By signing this agreement, I hereby authorize the Doctor to treat my condition as she deems appropriate. It is understood and agreed the amount paid to McAvoy Chiropractic for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time. The patient also agrees to total responsibility for all bills incurred in this office.

Patient Signature: ____ Date: ___/____/20______

Guardian or Spouse, if authorizing care: ____

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

By signing below, I am stating that I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: ____ Date:____/____/20______

If the patient is a minor: I hereby authorize McAvoy Chiropractic to treat my child: _____________________

Parent/Guardian Signature: ____ Date: ____/____/20______

INFORMED CONSENT: McAvoy Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is equally important that each patient understand the methods that will be used to attain that objective. This will prevent any confusion or disappointment.

Health is defined as a state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Subluxation(s) is/are misalignment of one (segmental subluxation) or more (global subluxation) of 24 vertebra in the spinal column or extremities which causes alteration of nerve function. This results in lessening of the body's innate ability to express its maximum health potential.

The nature of chiropractic treatment- The doctor will use her hands or a mechanical device in order to move your joints. This is called a chiropractic adjustment. The purpose of a chiropractic adjustment is to reduce or eliminate subluxation(s). You may feel a "click" or "pop," such as the noise when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as examination, x-rays, hot or cold packs, electric muscle stimulation, therapeutic ultrasound, IASTM, cold laser therapy, and traction may also be used.

Nutrition – Any nutritional recommendations are not for the treatment or prevention of any disease or condition. Nutritional recommendations are made solely for the purpose of supporting the physiological and biochemical processes of the human body.

Possible risks or probability of risks occurring – As with any health care procedure, complications, although rare, are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications. The risks of complications due to chiropractic treatment have been described as "rare," about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare." I will make every effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

Other treatment options that could be considered may include the following:

- Over-the-counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated – Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make future rehabilitation more difficult.

We do not offer to diagnose or treat any disease or condition. However, if 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 a health care provider who specializes in that area. We offer no guarantee of symptom relief. We do not offer advice regarding treatment prescribed by others. Our only practice objective is to reduce or eliminate subluxation(s), and support the physiological and biochemical processes of the human body.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

____________________________ ______________________________________ _______________________

Patient Name (Printed) Patient or Guardians Signature Date