New Patient Form - Pray Chiropractic

Patient Information

Last Name:_____ First Name: _____ MI _____

Email:_____ Patient Employer/School: _____

Address: _____ Occupation: _____

City: _____ Work Address:_____

State: _____ Zip: _____ _____ Phone: _____

Phone: _____ ☐ Home ☐ Cell ☐ Work In case of emergency, contact: _____ _____

SSN or DL#: _____ Relationship: _____ Phone:_____

Sex ☐ M ☐ F Age: _____ Birth Date: _____ How did you hear about our office? ☐ Google ☐ Facebook ☐ Yelp

☐ Married ☐ Single ☐ Partnered ☐ Children How Many:_____ ☐ Sign ☐ Website ☐ Patient Referral ☐ Other:_____

Main Complaint(s):_____

Is condition: ☐ Work related ☐ Auto Related ☐ Fall ☐ Home Injury

Health History

Have you ever been to a chiropractor before? ☐ Yes ☐ No If yes, who and when?_____

_____

Pregnant? ☐ Yes ☐ No

Any Surgeries? ☐ Yes ☐ No If yes, list them 1. _____ 2. _____ 3. _____

Major accidents or falls? _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, what kind and when?_____

Date of last physical examination _____

List all medications currently taking_____

List all injuries including sports injuries, work injuries, auto accidents, and home injuries_____

_____

Please check all of the following that apply to you:

- ☐ Alcohol/Drug Dependence
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke (Date) _____
- ☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
- ☐ Taking Birth Control Pills
- ☐ Dizziness / Fainting
- ☐ Numbness in Groin/Buttocks
- ☐ Cancer/Tumor (Explain) _____
  _____
- ☐ Other Health Problems (Explain) _____
  _____
- ☐ Osteoporosis
- ☐ Epilepsy/Seizures
- ☐ Pacemaker
- ☐ Herniated Disc
- ☐ Prostate Problems
- ☐ Menstrual Problems
- ☐ Urinary Problems
- ☐ Currently Pregnant, # Weeks _____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Marked Morning Pain/Stiffness
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Visual Disturbances

Family History

Autoimmune Dis.	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	☐ Other	_____
Bleeding Disorder	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No		_____
Clotting Disorder	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No		_____
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No		_____

Activities of Daily Living

How does this condition interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	☐	☐	☐	☐
Rising out of chair	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lying Down	☐	☐	☐	☐
Bending Over	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Using a computer	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐
Looking over shoulder	☐	☐	☐	☐
Caring for family	☐	☐	☐	☐

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	☐	☐	☐	☐
Household chores	☐	☐	☐	☐
Lifting objects	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Showering or bathing	☐	☐	☐	☐
Dressing myself	☐	☐	☐	☐
Love life	☐	☐	☐	☐
Getting to sleep	☐	☐	☐	☐
Staying asleep	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐
Exercising	☐	☐	☐	☐
Yard work	☐	☐	☐	☐

Authorized Release of Medical Information

I have received or reviewed the privacy practice notice for Pray Chiropractic, P.C, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement. I authorized the release of my medical information with the following people:

_____ _____

_____ _____

Assignment and Release

On behalf of yourself and any patient for whom you are the parent or legal guardian, you 1) certify that the information on this form is accurate and up-to-date. 2) consent to treatment by Pray Chiropractic, PC 3) assign to Pray Chiropractic, PC any healthcare insurance or reimbursement benefits to which you are entitled for the care provided by Pray Chiropractic, PC authorize their payment directly to Pray Chiropractic, PC and authorize the use of your signature for this limited purpose, 4) agree to be primarily responsible for all charges owed to Pray Chiropractic, PC (other than those included in any pre-paid offer), including attorney fees, court costs, and other expenses of collection, 5) consent to Pray Chiropractic, PC releasing any "protected health information," as defined by federal HIPAA regulations, for the purposes allowed by law, and 6) acknowledge receipt of Pray Chiropractic, PC, Notice of Privacy Practices.

_____ _____

Printed name of Patient, Parent, Guardian or Personal Representative **Signature of Patient, Parent, Guardian or Personal Representative**

Relationship: _____ **Date:** _____