

New Patient Form - Pray Chiropractic

Date: _____

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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other _____
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> 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		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising out of chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household chores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Showering or bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Love life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using a computer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking over shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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:

Printed name of Patient, Parent, Guardian or Personal Representative

Signature of Patient, Parent, Guardian or Personal Representative

Relationship: _____

Date: _____