New Patient

melby chiropractic

Introduction

Name _____ Today's Date ___/___/_____

Name you prefer to be called _____ Age _____ Birthdate ___/___/_____ Sex: ☐M ☐F

Street Address _____

City _____ State _____ Zip _____

Phone (_____)_____-_____ ☐ Home ☐ Work ☐ Cell E-mail _____

Employer/School _____ Occupation/Major _____

Marital Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Separated ☐Divorced

Spouse's name _____ Names of children _____

How did you hear of Melby Chiropractic? _____

Current Condition

Describe major complaint: _____

When did this start? ____/____/_____ Describe how this began: _____

Severity of complaint (10 is most severe) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Describe the pain: ☐Sharp ☐Stabbing ☐Burning ☐Achy ☐Dull ☐Stiff & Sore ☐Other: _____

Frequency of complaint: ☐Comes and goes ☐Constant

Does this complaint shoot to any areas of your body? ☐ No ☐ Yes (Describe) _____

Does anything make the complaint better? ☐Ice ☐Heat ☐Rest ☐Movement ☐Stretching ☐Medications ☐Other: _____

Does anything make the complaint worse? ☐Sitting ☐Standing ☐Walking ☐Lying ☐Sleep ☐Overuse ☐Other: _____

Which daily activities are being affected by this condition? _____

Have you received any other treatment for this condition? ☐No ☐Yes (Describe) _____

Have you had any previous interventions in this area? ☐No ☐Yes (Describe) _____

Have you taken any medications for this condition? ☐No ☐Yes (Describe) _____

Have you had any diagnostic testing? ☐X-rays ☐MRI ☐CT ☐Other: _____

Describe any other issues you'd like to discuss with Dr. Melby: _____

For Women Only

Are you pregnant? ☐Yes ☐No ☐Maybe If yes, what is your due date? ___/___/_____ Nursing? ☐Yes ☐No

Office Use Only

	4FS 3C 2T 2L CF&E Davis
	Norm N/CALL N/CE&X

Medical History

Notable family health history (cancer, diabetes, heart disease, etc.): _____

_____

List any other significant injuries you have had and dates: _____

_____

List any other surgeries you have had and dates: _____

_____

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Medications

Medication Name	Dosage

Medication Allergies

Medication Name	Reaction	Onset Date	Additional Comments

Select All That Apply

General:
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue

Musculoskeletal:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones

Neurological:
- ☐ Numbness or Tingling Sensation
- ☐ Dizziness or Light Headedness
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Stroke

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Difficult Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Bed Wetting

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Heart Beat Changes
- ☐ Blood Pressure Changes
- ☐ Swelling of Hands, Ankles, or Feet

Ears, Nose, and Throat
- ☐ Bleeding Gums/Mouth Sores
- ☐ Swollen Throat or Voice Change
- ☐ Swollen Glands in Neck
- ☐ Ringing in Ears
- ☐ Ear Ache or Drainage
- ☐ Sinus/Allergy Problems
- ☐ Nose Bleeds
- ☐ Hearing Loss

Eyes and Vision:
- ☐ Wear Contacts or Glasses
- ☐ Blurred or Double Vision
- ☐ Glaucoma
- ☐ Eye Disease or Injury

Endocrine, Hematologic, and Lymphatic
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Heat or Cold Intolerance
- ☐ Dry Skin
- ☐ Glandular or Hormone Problems
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Immune System Disorder

Skin and Breasts:
- ☐ Rash and Itching
- ☐ Change in Skin Color
- ☐ Change in Hair or Nails
- ☐ Non-healing Sores
- ☐ Change in Appearance of a Mole
- ☐ Breast Pains
- ☐ Breast Lump
- ☐ Breast Discharge

Other:

_____

_____

_____

_____

Policies

Consent to Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Receipt of Privacy Policy

The Melby Chiropractic Privacy Notice includes a complete description of the uses and disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and obtain payment for that treatment. It has been explained to me the Privacy Notice will be available to me in the future at my request. Melby Chiropractic may use and/or disclose my PHI. I understand that I have a right to request that they restrict how my PHI is used; however, they are not required to agree to any restrictions that I request.

I understand that the office may need to contact me at times regarding office matters. I authorize the office to contact me in the following manner: by phone, email or regular mail. Messages may be left on an answering device/voicemail or with the person answering my phone.

I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, Melby Chiropractic has the right to refuse to treat me. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures contained in the Privacy Notice, then the practice will not treat me.

I have read and accept the Privacy Notice posted by Melby Chiropractic and authorize the use and/or disclosure of my health information in the manner described therein.

Electronic Health Records

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Insurance Authorizations

I request that payment be made on my behalf to Melby Chiropractic for any services furnished to me. This is a direct assignment of my benefits under my policy. This authorization is in effect until I choose to revoke it.

I authorize the release of any and all pertinent information to any insurance company, adjuster or attorney involved in my case.

Name of Patient (Printed):_____

Signature of Patient:_____ Date: ___/___/_____

Name (Printed) of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____ Date: ___/___/_____

Doctor of Chiropractic Name: Jeffrey C. Melby, D.C.

Signature of Doctor of Chiropractic:_____ Date: ___/___/_____