

New Patient Information

How were you referred to our office? _____

Name: _____ Age: _____ Sex: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____ Cell Provider: _____

Social Security #: _____ Birthdate: _____ E-mail address: _____

Race: _____ Ethnicity: Hispanic Non Hispanic Marital Status: Single Married Widowed Divorced

Occupation: _____ Employer: _____

Employer's Address: _____ Employer Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Parent's Name if Patient is Minor/Child: _____ Parent's Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Name of Nearest Relative: _____ Address: _____ Phone: _____

Family Medical Doctor: _____ Phone: _____

Please check any and all insurance coverage that may be applicable in this case:

- Major Medical Medicaid Medicare Worker's Compensation Auto Accident
 Medical Savings Account Flex Plan Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

CONTACT RELEASE INFORMATION: I agree to permit this chiropractic office and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. 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 encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Doctor Signature _____ DATE _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto Work Other: _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

If Auto Accident: Date: _____ Time: _____ Location: _____

Were You: Driver Passenger Wearing Seatbelt
 Unconscious Transported by Ambulance Treated in E.R.

Was there a Police Report, if yes, what Police Dept: _____

If Work Accident: Date: _____ Time: _____ Location: _____

Describe injury & how it happened: _____

Accident was reported to: _____ Days lost from work: _____ Date of last physical examination: _____

Describe your pain (check all that apply):

- Aching Burning Cramping Deep Dull Non-radiating
- Radiating to _____ Sharp Squeezing Stabbing Throbbing Tightness Vague

What, if anything, gives you RELIEF (check all that apply):

- Activity Lying down Movement Pain relievers Rest Sitting
- Standing Stretching Turning Twisting Walking Other: _____

What, if anything, makes it WORSE (check all that apply):

- Activity Lying down Movement Pain relievers Rest Sitting
- Standing Stretching Turning Twisting Walking Other: _____

Was onset of pain: sudden or gradual?

Rate your pain on a scale of 1 to 10: _____

When do you notice it: End of day Night Morning

How often do you feel it: Constant Frequent Occasional

Do you have a history of Stroke Hypertension?

Have you had any major illnesses, injuries, falls, auto accidents or surgeries (with dates)? Women, please include information about childbirth (with dates): _____

Have you been treated for any health condition by a physician in the last year? Yes No

If yes, describe: _____

What medications or drugs are you taking? _____

Do you have any allergies to any medications? Yes No If yes, describe: _____

Do you have any allergies of any kind? Yes No If yes, describe: _____

Do you have any Congenital Condition? Yes No If yes, describe: _____

Women: Are you pregnant? Yes No

PATIENT Signature _____ DATE _____

Doctor Signature _____ DATE _____

Review of Systems

Have you had or do you now have any of the following symptoms/conditions?
Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now		P = Previously
Headaches	_____	Frequent Colds	_____
Lights Bother Eyes	_____	Sinus Problems	_____
Loss of Smell	_____	Fever	_____
Loss of Taste	_____	Coughing Blood	_____
Buzzing in Ears	_____	Diabetes	_____
Ears Ring	_____	Ulcers	_____
Dizziness	_____	Gall Bladder Problems	_____
Loss of Balance	_____	Unusual Bowel Patterns	_____
Fainting	_____	Indigestion Problems	_____
Neck Pain	_____	Menstrual Difficulties	_____
Stiff Neck	_____	Difficulty Urinating	_____
Shoulder Pain	_____	Chest Pains/Tightness	_____
Elbow Pain	_____	Breathing Problems	_____
Numbness in Fingers	_____	Pacemaker	_____
Hands Cold	_____	High Blood Pressure	_____
Rheumatoid Arthritis	_____	Low Blood Pressure	_____
Back Pain	_____	Circulating Problems	_____
Numbness in Toes	_____	Heart Disease	_____
Feet Cold	_____	Stroke	_____
Weakness in Extremities	_____	Ruptures	_____
Hip Pain	_____	Excessive Bleeding	_____
Knee Pain	_____	Depression	_____
Ankle Pain	_____	Alcoholism	_____
Muscle Spasms	_____	Eating Disorder	_____
Joint Pain/Swelling	_____	Drug Addiction	_____
Arthritis	_____	Loss of Memory	_____
Osteoarthritis	_____	Seizures/Epilepsy	_____
Fatigue	_____	Osteoporosis	_____
Sleeping Problems	_____	Broken Bones/Fractures	_____
Nervousness	_____	Weight Loss/Gain	_____
Irritability	_____	Cancer	_____
Tension	_____	HIV Positive	_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

O = OFTEN S = SOMETIMES N = NEVER

Caffeine _____	Vigorous Exercise _____
Drug Use _____	Moderate Exercise _____
Alcohol Use _____	High Stress Activity _____

Tobacco Use _____ Number of Years _____ Years Quit _____

PATIENT Signature _____ DATE _____

Doctor Signature _____ DATE _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

INFORMED CONSENT

PATIENT NAME _____

Clinic Name Forsyth Chiropractic

Doctor's Name Dr. Travis Sellers and/or Dr. Hunter Schaff

Address 517 Coy Blvd, PO Box 99, Forsyth, MO 65653

Phone (417) 546-2411 Fax (417) 546-2730

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE _____

Printed Name

Signature

Signature of Parent or Guardian (if a minor)