

NEW PATIENT INFORMATION

Patient Information



McBroom
Chiropractic

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	HEIGHT: _____' _____" WEIGHT: _____ lbs
DATE OF BIRTH:	AGE: GENDER: MARITAL STATUS:
SOCIAL SECURITY NUMBER:	
EMPLOYER NAME:	EMPLOYER ADDRESS:
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
WORK PHONE:	POSITION TITLE:
DESCRIBE THE REASON FOR THIS VISIT:	
IS THE PURPOSE OF THIS APPOINTMENT RELATED TO: <input type="checkbox"/> JOB <input type="checkbox"/> SPORTS <input type="checkbox"/> AUTO <input type="checkbox"/> FALL <input type="checkbox"/> HOME INJURY <input type="checkbox"/> CHRONIC DISCOMFORT <input type="checkbox"/> OTHER PLEASE EXPLAIN:	
IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	PERCENT OF DAY PAIN IS PRESENT <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
WHEN DID THIS CONDITION BEGIN?	
HAS THIS CONDITION: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> STAYED CONSTANT <input type="checkbox"/> COME AND GONE	
DOES THIS CONDITION INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES PLEASE EXPLAIN:	
HAS THIS CONDITION OCCURRED BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:	
DOCTOR'S NAME:	
TYPE OF TREATMENT:	
RESULTS:	
EMERGENCY CONTACT NAME:	PHONE NUMBER:
RELATIONSHIP TO THE PATIENT:	ADDRESS:

MEDICATIONS YOU TAKE

<input type="checkbox"/> CHOLESTEROL MEDICATIONS	<input type="checkbox"/> BLOOD PRESSURE MEDICINE
<input type="checkbox"/> STIMULANTS	<input type="checkbox"/> BLOOD THINNERS
<input type="checkbox"/> TRANQUILIZERS	<input type="checkbox"/> PAIN KILLERS (INCLUDING ASPIRIN)
<input type="checkbox"/> MUSCLE RELAXERS	<input type="checkbox"/> OTHER:
<input type="checkbox"/> INSULIN	<input type="checkbox"/> OTHER:
<input type="checkbox"/> VITAMINS & SUPPLEMENTS:	

HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how much per day _____
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how much per week _____
DO YOU DRINK COFFEE, TEA, OR SODA <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, how much per day _____
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU WEAR: <input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

HEALTH CONDITIONS

INSTRUCTIONS: Please check each of the diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> SEVERE OR FREQUENT HEADACHES	<input type="checkbox"/> THYROID PROBLEMS	<input type="checkbox"/> PAIN IN ARMS/LEGS/HANDS	<input type="checkbox"/> NUMBNESS	FOR WOMEN ONLY: ARE YOU PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN IS YOUR DUE DATE? ARE YOU NURSING? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE YOU TAKING BIRTH CONTROL? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>DO YOU:</i> EXPERIENCE PAINFUL PERIODS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE IRREGULAR CYCLES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAVE BREAST IMPLANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HEART SURGERY/PACEMAKER	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> ALLERGIES	
<input type="checkbox"/> LOWER BACK PROBLEMS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> DIABETES	
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> DIFFICULTY BREATHING	<input type="checkbox"/> ULCERS/COLITIS	<input type="checkbox"/> SURGERIES:	
<input type="checkbox"/> PAIN BETWEEN SHOULDERS	<input type="checkbox"/> KIDNEY PROBLEMS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> ASTHMA	
<input type="checkbox"/> CONGENITAL HEART DEFECT	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> LOSS OF SLEEP	
<input type="checkbox"/> FREQUENT NECK PAIN	<input type="checkbox"/> CHEMOTHERAPY/ CANCER	<input type="checkbox"/> SHINGLES	<input type="checkbox"/> DIZZINESS	

INFORMATION ABOUT POSSIBLE RISK OF CHIROPRACTIC TREATMENT

You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of a treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health procedure, complications may arise during treatment. These complications include soreness, muscle or ligament strain, dislocations, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:
WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?	
<input type="checkbox"/> PATIENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> WORKERS COMP <input type="checkbox"/> AUTO INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> HEALTH INSURANCE	

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: