LIBERTY CHIROPRACTIC

NEW PATIENT INFORMATION

Name:_____ Gender:_____ Date:_____

What you prefer to be called:_____ Age: _____ Birth Date: _____

Address:_____ City/State/Zip:_____

Phone #: _____ (cell) _____ (home)

E-mail: _____ Preferred Method of Contact:_____

Height: _____ Weight: _____

Race: □ Asian □ Black or African American □ White □ Other □ Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Occupation: _____ Employer: _____

Marital Status (*Circle One)*: Single Married Separated Divorced Widowed

Emergency Contact: _____ Relation: _____ Phone #: _____

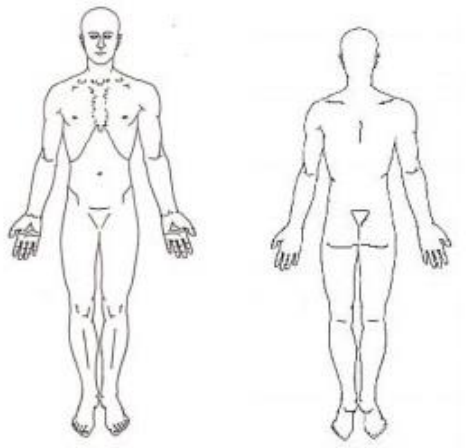
How did you hear about our office? _____

CHIEF COMPLAINT/CHIROPRACTIC HISTORY

When did your condition begin? _____

Have you had these symptoms before? □ Yes □ No Date of prior condition:_____

Indicate on the figures below where you have pain/symptoms:



List chief symptoms in order of severity:

1. _____
2. _____
3. _____
4. _____

How often do you experience the symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

On the scale below, rate the pain intensity by circling the appropriate number:

0 (No Pain)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** (Unbearable pain)

How would you describe the type of pain? (e.g., sharp, dull, tingling) _____

What activities make the pain worse? _____

What activities reduce the pain? _____

What activities do you do at work?_____

What activities do you do outside of work? _____

Other Doctors seen for this condition:_____

Have you ever seen a chiropractor before? □ Yes □ No Primary Care Physician: _____

MEDICAL AND FAMILY HISTORY

Check all symptoms that apply to you:

□ Headaches	□ Tingling/numbness in arms/hands	□ Chest Pain	□ Unexplained weight loss
□ Neck Pain/Stiffness	□ Tingling/numbness in legs/toes	□ Knee Pain	□ Fatigue
□ Back Pain/Stiffness	□ Loss of balance/dizziness	□ Hip Pain	□ Night Sweats
□ Shoulder Pain	□ Shortness of breath	□ Fever	□ Blood in urine
□ Other_____		□ Night Pain	□ Pain unrelieved by rest

List all prescription and over the counter medications you are currently taking along with any supplements:

Name of Medication	Strength (i.e.,10 mg)	Instructions (i.e.,1 per day)

Are you allergic to any medicines? *Check here if you do not have any medicinal allergies:* □

Name of Drug (i.e., penicillin)	Symptom(s) (i.e., headaches)

List all surgical procedures you have had: _____

_____

List any diagnostic tests you have had related to this condition (i.e., x-rays, MRI, etc.):_____

_____

Do you have a *personal* history of: □ Cancer □ Diabetes □ Heart Disease □ Stroke

Other serious illnesses:_____

List any medical conditions *within your immediate family*:_____

_____

Smoking status:_____ For women: Are you pregnant? □ Yes □ No

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request, and direct this clinic, its doctors and staff to preform examinations and any treatment that in their judgement, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

_____ _____

Parent/Guardian or Custodian Signature Date

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES, AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor and their affiliated providers to administer treatment, physical examination, chiropractic care, physical therapy, or clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment including, but not limited to manipulation, physical therapy modalities, soft tissue massage, and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. In order to ensure that all of my healthcare providers function as a team, I hereby grant the providers and clinical staff of this clinic to communicate with and relay any information about my condition to my other healthcare providers. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. Understand that if an insurance company initially pays for my treatment and later requests reimbursement from this clinic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

_____ _____

Patient's or Guardian's Signature Date

PATIENT CONSENT FORM

(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

--Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
--Obtaining payment from third party payers (e.g., my insurance company)
--The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Today's Date: _____

Print Patient Name: _____

Patient/Guardian's Signature: _____