

New Patient Information

Welcome! Please allow our staff to photocopy your driver's license & insurance card (if applicable)



PLEASE PRINT CLEARLY:

Today's Date: ___/___/20___

Full Name: _____ E-mail: _____ Gender: M F Age:___ DOB: ___/___/___

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

Social Security#: _____ - _____ - _____ Driver's Lic. #: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Fax: (_____) _____ May we e-mail you?: Y N

Marital Status: S M D W # Children: ___ Work Status: FT PT R Student

Females: Last Menstrual Period: ___/___/___ Pregnant: Y N Nursing: Y N

Employer: _____ Occupation: _____ Work Phone: (_____) _____

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

Spouse, Parent or Guardian Name: _____ Age: ___ DOB: ___/___/___

Spouse's Employer: _____ Occupation: _____ Work Phone: (_____) _____

Emergency Contact Person: _____ Relationship to Patient: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Do you have health insurance: Y N Carrier Name: _____ Group Name: _____

Policy #: _____ Group #: _____ Ins Card Copied DL Copied

Who may we thank for referring you? _____ Internet Yellow Pages Doctor Yellow Book

Please initial acknowledging that patient is responsible for patient portion of insurance charges and/or payment in full for non-covered items or services. If there is no insurance coverage, patient is responsible for balance of service at time of service each visit: _____

We want you to know how your Protected Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we begin care, please read and sign this consent form stating understanding and acknowledgement regarding how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI, please ask us for our complete HIPAA Privacy Notice as we have that available upon request at the front desk.

-The patient understands and agrees Hanna Chiropractic Wellness Center to use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare options and coordination of care.

- The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. Patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This practice is not obligated to comply with those restrictions.

-A patient's written consent need only be obtained one time for all subsequent care given to patient in this office.

-Patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

-For your security and right to privacy, the staff has been trained in the area of patient privacy and a privacy official has been designated to insure these procedures in our office. We have taken precautions to assure that your records are not readily available to those unauthorized to access them.

-Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

-If patient refuses to sign this consent for the purpose of treatment, payment & healthcare operations, this facility reserves the right to refuse service.

I have read and understand my how my PHI will be used and I agree to these policies and procedures. Signature required on last page.

Health Concerns: (please list in priority order & use back of questionnaire or additional paper if needed)

1. _____
2. _____
3. _____

Treatment: What type of treatment are you looking for?

- Symptom Relief Correctional Care Total Wellness Care All 3 previous choices

Symptoms/Complaints: (relating to your primary complaint(s))

When did Symptoms begin? _____ What initiated symptoms? _____

Have you previously been treated for this condition by another provider? Y N

If yes, by whom? _____ Treatment received: _____

Have you had any reactions to previous treatment: Y N Describe: _____

If this is a recurrence, when did you initially notice this problem: _____

Has worsened over time: Y N Same Better Worse How long does it last?: All day Hours Minutes

Is this condition interfering with your: Work Sleep Daily Routine Recreation Other: _____

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: _____

What makes the problem worse: Standing Sitting Lying Bending Lifting Twisting Other: _____

Have you found things that relieve symptoms? Y N If yes, describe: _____

Do you have other conditions or symptoms that may be related to current symptoms? Y N If yes, what?: _____

Have you ever been in an auto accident or other physical trauma: Past year 1-5 years 5+ years Never

Describe: _____

P / C

- Headache
- Fascial Pain
- Blurred Vision
- Dizziness
- Earache
- Eye pain
- Forgetfulness
- Confusion
- Sinusitis
- Teeth Grinding
- Dry Mouth
- Excessive Thirst
- Unpleasant Taste
- Neck Pain
- Sore Throat
- Lump in Throat
- Swallowing Pain
- Unsteady Voice
- Shoulder Pain
- Persistent Coughing
- Chest Pressure
- Slow Heart Rate
- Rapid Heart Rate

P / C

- High Blood Pressure
- Low Blood Pressure
- Abdominal Pains
- Nausea/Vomiting
- Poor Appetite
- Fullness of Bladder
- Urination Difficulty
- Frequent Urination
- Constipation
- Hemorrhoids
- Decreased Sex Drive
- Menstrual Irregularities
- Elbow/Hand Pain
- Tingling in Hands
- Clammy Hands
- Low Back Pain
- Hip Pain
- Knee Pain
- Poor Circulation
- Swollen Joints
- Joint Stiffness
- Swollen Ankles
- Ankle/Foot Pain

P / C

- Tingling in Feet
- Walking Problems
- Sore Muscles
- Weak Muscles
- Paralysis
- Shakiness
- Sweating
- Insomnia
- Fainting
- Convulsions
- Irritability
- Impatience
- Fatigue
- Feel Loss of Control
- Other: _____

*Additional *

(Please check all that apply)

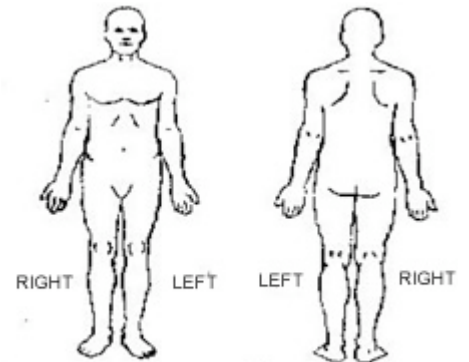
- Seizures (Epilepsy)
- Transplant
- Surgically Implanted Device
- Pacemaker

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting: III Tingling: :::

Burning: XXX Cramping: ^^

Numbness: --- Dull: ###



Allergies: (please check and list all that apply)

- Food: _____
- Medications: _____
- Seasonal: _____
- Other: _____

Medications: Please list all medications you are taking, their intended purpose, and the date you began taking them:

Scars/Surgical Procedures (Please list all) : _____

Were they recommended to you? Y N If yes, by who? _____

Miscellaneous & Habits:

Are you: Left handed Right handed Ambidextrous Exercise: Light Moderate Heavy Type: _____

Frequency: _____ Approximately how many hours do you sleep per night? _____

How many meals per day do you eat? _____ How much water per day do you drink: _____

Alcohol consumption: Light Moderate Heavy None

Coffee, Tea: Light Moderate Heavy None Soda, Diet soda: Light Moderate Heavy None

Tobacco: Light Moderate Heavy None Stress Level: Light Moderate Heavy None

Work Activity: Heavy Labor Light Labor Mostly Sitting Mostly Standing Walking/Moving Driving

Uninterrupted Sleep: Y N Do you feel rested upon waking?: Y N Vivid Dreams?: Y N

How many bowel movements do you have each day? _____

Personal & Family History: Identify conditions that you or any of your family members have now or have previously had.

(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

____ Allergies	____ Eczema	____ Miscarriage(s)	____ Tumor(s)
____ Alcoholism	____ Emphysema	____ Mumps	____ Ulcer(s)
____ Anemia	____ Epilepsy	____ Pleurisy	____ Female Organ Dysfunction
____ Cancer	____ Goiter	____ Pneumonia	____ Over weight
____ Deep Vein Thrombosis	____ Gout	____ Polio	____ Headaches/migraines
____ Detached Retina	____ Heart Disease	____ Rheumatic Fever	____ Addiction
____ Diabetes	____ HIV/AIDS	____ Stroke	____ Other _____

Informed Consent to Chiropractic, Acupuncture and Massage Care

Chiropractic Adjustment: The doctor will use his/her hands or a mechanical device in order to adjust your spinal joints. This procedure is called a spinal adjustment and is intended to reduce spinal subluxation (slight dislocation of the spinal joints). You may feel a 'click' or a 'pop' as well as a movement of the joint. Various ancillary procedures such as, support pillows, cold laser, traction or hot/cold packs may also be used. Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Fracture of bone, muscular strain, ligament strain, dislocation of joints, injury to intervertebral discs, nerves or spinal cord are all rare occurrences and generally result from some underlying weakness of the bone or surrounding tissues. Usually, there is an underlying, pre-existing vascular condition like atherosclerosis that contributes in a stroke resulting after a neck adjustment. A minority of patients may notice stiffness or soreness after the first few days of treatment. We will not accept individuals for treatment unless we feel confident that we can safely help them.

Acupuncture: The provider will use procedures including but not limited to acupuncture, moxabustion, cupping, electro acupuncture, herbology and modes of physiotherapy.

Risks: Risks include but are not limited to, slight bruising, tingling near the needling sites that may last a few days, nausea, infection and blisters. There have been reported instances of fainting, scarring, spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy.

Massage: The provider will perform soft tissue or muscle work using his/her hands.

Risks: Risks may include muscle weakness, muscle and joint soreness, ligament strain, muscular strain.

Probability of Risks: The risks and complications of chiropractic care, acupuncture and massage have all been described as 'rare'. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by our screening procedures. The probability of adverse reaction due to ancillary procedures is also considered to be 'rare'.

Other treatment options which could be considered may include:

-*Over the counter analgesics* may cause irritation the stomach, liver and kidneys, and other side effects in 1,000 to 4,000 people per one million, and reportedly 16,500 die annually from their use.

- *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

-*Hospitalization and bed rest*, in conjunction with medical care adds risks of exposure to virulent communicable disease, loss of muscle tone and strength at the rate of 4% per day.

-*Surgery*, in conjunction with medical care adds the risks of infections, adverse reaction to anesthesia, disfiguring scar as well as an extended convalescent period in a significant number of cases. Serious neurological complications from neck surgery are 15,600 per million; mortality rates are 6,900 per million.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have had the following risks of my case explained to me. If you/ and/or the individual listed below understand the above information, please sign below. This signature authorizes treatment, acknowledges Notice of Privacy Practices and also authorization to submit to insurances (if applicable). Patient or guardian understands that he/she is responsible for payment of all services.

I have read or have had read to me, the explanation of care offered at this facility. I have had the opportunity to have any questions answered. I have fully evaluated the risks and benefits of undergoing treatment and hereby give my full consent to the items mentioned above.

Patient/guardian printed name

Signature

Date