New Member Contact Information

Date: ____________________ Social Security #: ______-______-________ File Number: ________________

First Name: ________________________ Middle Initial: ____ Last Name: ____________________________

Age: _______ Birth Date: _______ / _______ / _________ Gender: M F Marital Status: S M D W

Home Address: ____ Home Phone: ______-______-_________

City, State, Zip: ____ Work Phone: ______-______-_________

Cell Phone: ______-______-_________ Email Address: ____

Race/Ethnicity: ____White/Caucasian _____ Hispanic/Latino/Spanish Origin _____ Black/African American

___ Asian ____ American Indian _____ Native Hawaiian ____ Other: ______________________________

Language: _____ English _____ Spanish _____ Other: ____________________________________

Names and Ages of Children: ____

Occupation: ______________________________ Employer Name: _________________________________

Spouse's Name: ___________________________ Spouse's Employer: _____________________________

Work Phone: ______-______-_________ Cell Phone: ______-______-_________

Spouse's Occupation: ____

In case of an emergency please contact: __________________________ Phone: ______-________-________

How were you referred to this office? ____

Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who? ____________________ When? ______________

Reasons for Visit: ____

How did you respond? _______________________________ Did they take X-Rays: Yes No

Health Lifestyle

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: ______________________

What activities? Running / Jogging / Weight Training / Cycling / Yoga / Pilates / Swimming / Other: ________

Do you smoke? Yes No How much? _________ Do you drink alcohol? Yes No How much / week? ________

Do you drink coffee? Yes No How many cups / day? _______ Do you use recreational Drugs? _____________

Do you take any supplements (i.e. vitamins, minerals, herbs)? _______________________________________

Patient's Initials: ___________

Patient Name: ____________________________ Patient #: ___________

Pregnancy History

Do you have a birth plan? Yes No Is this a planned pregnancy? Yes No

Are you receiving prenatal care from an: OB/GYN Midwife Both Other: _______________________

How far along in the pregnancy term are you? _________________ Are you taking birthing classes? Yes No

Have you had any medical diagnoses during this pregnancy? Yes No What: ____________________________

Has any in-utero testing been done? Yes No Have you had any x-rays taken during this pregnancy? Yes No

Have you had an ultrasound? Yes No How many? ______________ How long? ______________

Did/Do you experience morning sickness? Yes No How long? ___________________________

Are you under emotional stress during this pregnancy? Yes No

Are you supported through your pregnancy? Yes No Are you enjoying being pregnant? Yes No

What medications are you taking or have been prescribed during your Pregnancy? _______________________

Have you smoked cigarettes during your pregnancy? Yes No How often? _____________________________

Have you had alcohol during your pregnancy? Yes No How often? _________________________________

Have you exercised during your pregnancy? Yes No How often? ___________________________________

Have you had any caffeine during your pregnancy? Yes No How often? _______________________________

Purpose of Visit

Main Complaint: ________________________________ When did this condition begin? ______/_____/_____

Is this purpose related to an auto accident / work injury? Yes No If so, when: __________________________

Did it begin (circle one): Gradual / Sudden / Progressive over time

What activities make your symptoms worse? ____

What have you found that makes your symptoms better? ____

Type of pain: Sharp / Dull / Ache / Burn / Throb / Spasm / Numb / Tingling / Shooting / Other: _____________

Does the pain travel into your: ___Arm ___Leg ___Does not travel Is this condition getting worse? Yes No

How often do you experience these symptoms throughout the day? (circle one) 100% 75% 50% 25% 10%

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: __________________

Have you experienced this condition before? Yes No If so, please explain: _____________________________

Who have you seen for this? _____________________________ What did they do? _______________________

How did you respond? ____

Patient's Initials: ___________

Patient Name: ____________________________ Patient #: ___________

Health Conditions

Please mark **"1"** any health condition you are currently experiencing, mark **"2"** for any condition you have experienced in the past, and leave blank if never. A complete understanding of your health history will help us facilitate your care.

	Neck Pain		Visual Disturbances		TMJ/Pain/Clicking
	Pain into your shoulders/arms/hands		Coldness in hands		Seizures
	Numbness/tingling in arms/hands		Thyroid conditions		Ear Infections/Earaches
	Hearing disturbances		Sinusitis		Loss of Smell or Taste
	Weakness in grip		Allergies/Hay fever		Stroke
	Headaches		Recurrent Colds/Flu		Inflammation of Throat
	Dizziness		Low Energy/Fatigue		Muscle Spasm
	Heart Palpitations		Recurrent Lung Infections/Bronchitis		High Blood Pressure
	Heart Murmurs		Asthma/Wheezing		Low Blood Pressure
	Tachycardia		Shortness of Breath		Anemia
	Heart Attacks/Angina		Cancer		Pain on Deep Inspiration/Expiration
	Mid Back Pain		Nausea		Kidney Problems
	Pain in Ribs/Chest		Ulcers/Gastritis		Sleeping Problems
	Indigestion/Heartburn		Hypoglycemia		Gall Bladder Problems
	Injuries in your hips/knees/ankles		Recurrent Yeast Infections		Tired/Irritable when you're hungry
	Pain into your hips/legs/feet		Coldness in your legs/feet		Constipation / Diarrhea
	Muscle cramps in your legs/feet		Numbness/tingling in your legs/feet		Menstrual irregularities/cramping
	Reflux		Sexual dysfunction		Hernia
	Recurrent bladder infections		Prostate Trouble		Arthritis
	Frequent/difficulty urinating		Inability to control bladder		Swollen Ankles
	Intestinal Gas		Low back pain		Tailbone/Coccyx Pain
	Unexplained weight loss		Varicose Veins		Pregnant

Explain: ____

Please list any health conditions not mentioned: ______________________________________

Please list any medications currently taking and their purpose: ______________________________

____

Please list all past surgeries: ____

Please list all previous major accidents and falls: ______________________________________

Patient's Initials: __________

Patient Name: ____________________________ Patient #: ____________

Family History

Many health problems are the result of hereditary weaknesses, thus information about your family members will give us a better picture of your overall health.

Name	Relationship	Past & Present Problem

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease or symptoms.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This may or may not cause pain. This also will result in alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to heal and achieve optimal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. One method is specific adjusting to the correct vertebral subluxation.

I, ___________________________________ have read and fully understand the above statement.

Any questions regarding the Doctor's objectives pertaining to care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient's Signature: ____ Date: _________________________

CA Signature: ____ Date: ________________________

Authorization for Care & Privacy Policy

I hereby authorize the doctors to work with my condition through the use of spinal adjustments, 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. The Doctor(s) will not be held responsible for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees will become immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Carlson Family Chiropractic, P.C. (CFC) 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 CFC and will be credited to my account upon receipt. If my account is delinquent for more than 90 days, I understand my account will be sent to a collection agency. If my account is sent to the collection agency, I agree to pay all collection fees and costs, including but not limited to, attorney's fees added for the collection of my account, whether or not suit is filed.

Patient's Initials: ________

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Disclosure of my protected health information without authorization is strictly limited to defined situations that include: emergency care, quality assurance, public health, research and law enforcement activities. I understand that this information can and will be used to: conduct, plan and direct my treatment; follow up with other healthcare providers who are involved in my treatment directly or indirectly; and to obtain payment from third party payers. I understand that any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining my consent. I know that:

- I may request restrictions on the disclosures of my health records
- I may inspect and receive copies of my records for a fee within 14 days with a request
- I may request to view changes to my records.

Patient's Initials: ________

I give permission to the doctors of CFC to use my address, phone number, email, and clinical records to contact me with appointment reminders, missed appointments, birthday cards, holiday related cards and information about treatment alternatives or other health related information. If CFC contacts me by phone, I give them permission to leave a message with a family member or on my answering machine or voicemail. I also give my permission to use my name and photo in testimonial format (if applicable). The display of any name or photo would ONLY be done after first receiving verbal authorization.

Patient's Initials: ________

I give CFC permission to treat me in a semi-open room where other patients are also being treated. I am aware other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

Patient's Initials: ________

You have the right to revoke authorization at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this authorization by mailing or hand delivering a written notice to CFC. The written notice must contain the following information:

1. Your name, SS number, and your date of birth
2. A clear statement of your intent to revoke this authorization
3. The date of your request and your signature

The revocation is not effective until CFC receives it. You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Carlson Family Chiropractic, P.C. has the right to refuse to provide care.

Patient's Initials: ________

A copy of this signed authorization will be provided to you upon request. This authorization shall remain in effect unless revoked in writing by the patient. By signing this form I am giving Carlson Family Chiropractic, P.C. permission to use and disclose my protected health information in accordance with the directives listed above.

Patient Name (Print): ______________________________ Patient #: ______________

Patient Signature: ______________________________ Date: ______________

Legal Representative Signature: ______________________________ Relationship: ______________

CA Signature: ______________________________ Date: ______________