



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 #: _____

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? _____

Is there anything that has relieved your symptoms? Yes No Describe: _____

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? _____

Secondary Complaint: _____ When did this condition begin? ____/____/____

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

What activities make your symptoms worse? _____

What activities improve your symptoms? _____

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: _____