Patient Name:____ Date: ___________________

I prefer to be called__________________________________ Sex: Male Female

Address_______________________________City_______________State__________Zip Code _______

Cell Phone _____________ Carrier __________ Email Address__________________________________

Are you enrolled in Medicare? Yes or No

Are you enrolled in Medicaid? Yes or No

Marital Status M S D W Date of Birth_________________________Age_______________________

Occupation_________________________Employer __________________Days off: S M T W TH F S

How Did You Hear About Us____

1. **Reason(s) For This Visit** (You will continue on Page #3 to fill in more questions about each symptom.)
What is your Worst Complaint or Primary Reason?_______________________________
What is your Second Worst Complaint? _______________________________________
What is your Third Worst Complaint? ____

Review of Symptoms (Please check all symptoms you have noticed now (present) or in the past.)

Past/Present	Past/Present	Past/Present	Past/Present	Past/Present
□/□Head feels heavy	□/□ Hands tremble	□/□ High blood pressure	□/□ Vision blurred	□/□Prostate problem
□/□ Neck pain	□/□ Loss of balance	□/□ Heart skips beats	□/□ Dry skin	□/□ Cancer
□/□ Jaw pain	□/□ Loss of memory	□/□ Rapid heartbeats	□/□ Excess sweating	□/□ Impotent
□/□ Mid back pain	□/□ Muscle twitching	□/□ Varicose veins	□/□ Nail Fungus	□/□ Fatigue
□/□ Back pain	□/□ Numb arms	□/□ Asthma	□/□ Stomach upset	□/□ Appetite change
□/□ Heel spurs	□/□ Numb fingers	□/□ Difficulty breathing	□/□ Constipation	□/□ Diabetes
□/□ Joint stiffness	□/□ Numb legs	□/□ Loss of taste	□/□ Diarrhea	□/□ Weight change
□/□ Joint pain	□/□ Numb toes	□/□ Loss of smell	□/□ Heartburn	□/□ Night sweats
□/□ Muscle cramps	□/□ Stroke	□/□ Trouble swallowing	□/□ Nausea	□/□ Depression
□/□ Muscle tension	□/□ Chest Pain	□/□ Ear noises/ringing	□/□ Bed wetting	□/□ Nervousness
□/□ Headaches	□/□ Hands/Feet blue	□/□ Frequent colds	□/□ Bladder problems	□/□ Irritable
□/□ Dizziness	□/□ Hands/Feet cold	□/□ Motion sickness	□/□ Difficult urinating	Other________
□/□ Double vision	□/□ Lightheadedness	□/□ Light bothers eyes	□/□ Frequent urination	Other_______

I. **Past Health History:**
   A. **Previous illnesses you've had in your life:**
   ____
   B. **Previous Injury or Trauma:**
   ____
   C. **Have you ever broken any bones? If so, which ones:**
   ____
   D. **Allergies:**
   ____

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E. Medications:

Medication/Vitamins Reason for taking

____

____

____

____

F. Surgeries:

Date Type of Surgery

____

____

____

____

Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____

____

____

____

*Women only: Are you on Birth Control Pills? (Yes/No) Are you pregnant?(Yes/No) Date of last period*________________

G. Family Health History:

Associated health problems of relatives:

____

____

____

Deaths in immediate family:

Cause of parents or siblings' death Age at death

____

____

____

II. Social and Occupational History:

A. Job description:

____

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B. Work schedule:

____

C. Recreational activities (hobbies):

____

D. Lifestyle (level of exercise, diet, alcohol, tobacco and drug use):
Do you exercise regularly? Y/N Type__________________Frequency__________Hours sleep/night______

Overall, how healthy is your diet?____Excellent____Good____Fair____Poor Water intake/day_______

Tobacco use? Y/N Frequency__________________Alcohol use? Y/N Frequency______________________

Caffeine use? Y/N Frequency__________________History of recreational drug use? Y/N Type__________

Primary Care Provider: Physician's Name(s)____

Previous chiropractic care: Physician's Name(s)____
Date of first visit_____________________Were X-rays taken? (Yes/No) Date of last visit_____________________

Is there anything else you would like to add?____

At Main Street Chiropractic, we want to ensure that you receive the best care possible. We believe in an integrative approach with all our patients and ask if you would please use the space below to list any other healthcare providers you are seeing at the moment. We would like your permission to share your case notes with your primary care physician as well as the providers you have listed. Please choose one of the following options:

- ○ Yes, I would like Main Street Chiropractic to send my treatment notes to
  - ☐ All my providers
  - ☐ Only my primary care provider
  - ☐ Only the providers listed below
- ○ No, I do not Main Street Chiropractic to share my treatment notes with any of my providers

1. Provider Name: ____
   Phone Number: ____
   Reason for Care: ____

2. Provider Name: ____
   Phone Number: ____
   Reason for Care: ____

3. Provider Name: ____
   Phone Number: ____
   Reason for Care: ____

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4. Provider Name: ____

   Phone Number: ____

   Reason for Care: ____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care.

Patient or Parent/Guardian Signature____Date_____________

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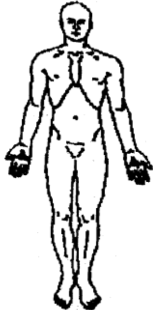
NEW PATIENT HISTORY FORM

Symptom #1 (What is your Worst Complaint?)____

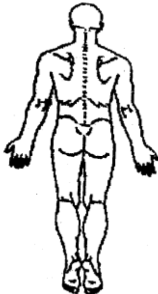


- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?

  ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it?

    ____
  - Have you had this symptom before this episode? Yes/No

  --If yes, when/how long ago?____



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe):

    ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate

- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day
- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____

  ____

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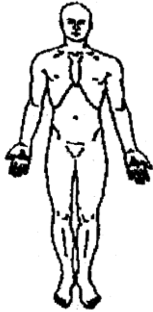
Symptom #2 (What is your Second Worst Complaint?)____

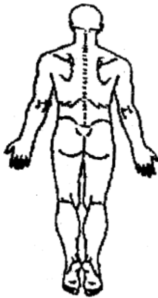


- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?

  ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it?

    ____
  - Have you had this symptom before this episode? Yes/No

  --If yes, when/how long ago?______________________________________



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    ____

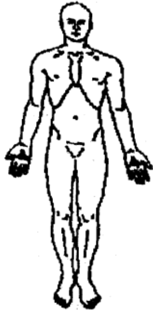
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ______________________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe):

    ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?______________________________________
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?______________________________________

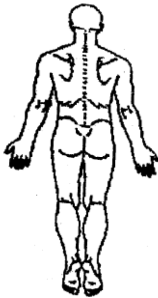
  ____

Symptom #3 (What is your Third Worst Complaint?)____



- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?
  ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin/ what caused it?
  ____
  - Have you had this symptom before this episode? Yes/No

  --If yes, when/how long ago?____



- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):
  ____

- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____________________
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, Other (please describe):
  ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate
- Is the symptom worse at certain times of the day or night? (Circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

- Since it started has this symptom been getting: better / same / worse? (Circle one)
- Who have you seen for this condition?____________________
- Please list what you have tried (ice/heat/treatments/surgeries) or taken for this condition (OTC/prescriptions) and did it help?____________________
  ____

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INFORMED CONSENT TO TREATMENT

The undersigned is the patient, ________________________, who explicitly and specifically consents to the treatment.

Doctor of Chiropractic, chiropractic assistants and massage therapists who use manual therapy techniques such as spinal adjustments, kinesio-taping/strapping, cryotherapy, neuromuscular reeducation, massage, should advise patients that there are or may be risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures, muscle strains and/or ligament sprains **following spinal manipulation.**

b) There have been reported cases of stroke following **cervical spinal adjustments**. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment, and may on rare occasion result in death. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.

c) **Kinesio-Taping/Strapping, heat and cryotherapy (ice):** skin reactions or burns

Chiropractic treatments, including spinal adjustments, have been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches being and other similar symptoms. The risk for injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor and his staff the nature and purpose of the treatments in general and my treatment in particular (including spinal adjustments) as well as the contents of this Consent. I consent to the treatment offered or recommended, including spinal adjustments. I intend this consent to apply to all present and future care.

TO BE COMPLETED BY PATIENT:

Date signed: ______________________________

Patient Signature: ______________________________ Witness Signature: ______________________________

Patient Name: ______________________________ (Please Print) Witness Name: ______________________________ (Please Print)

Do you prefer to receive upcoming scheduled visit notifications by:

Email (Circle one) Yes or No

Text message (Circle one) Yes or No

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Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by _____Main Street Chiropractic__________________ *(Clinic Name)*
or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.
You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it. I am aware this office DOES have open therapy areas.

____
Name of Patient (print)

____
Signature of Patient **Date**

____
Signature of Patient Representative **Date**

____
Relationship of Patient Representative to Patient

____
Office Representative **Date**

____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ______________________________
Cardholder Name (as shown on card): ______________________________
Card Number: ______________________________
Expiration Date (mm/yy): ______________________________
CVV: ______________________________
Cardholder ZIP Code (from credit card billing address): ______________________________

I,______________________________, authorize Main Street Chiropractic to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

______________________________ ______________________________

Customer Signature Date

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