New Patient Forms

Welcome to our practice!
Please print and complete the following forms to the best of your ability.

We know you have many choices when it comes to your health. Thank you for choosing us for your chiropractic needs.

WELCOME TO NEW HOPE CHIROPRACTIC!

Date__________________

First Name:_____________________________________ Last Name____

Age ____________ Birth Date: _____ / _____ / _____ Gender: ☐M ☐F

Home Address: ____

City, State, Zip: ____

Cell Phone ( ) _______________________ Home Phone ( )__________________________

Email Address:_____________________________________ Preferred method of communication? ☐Phone ☐Text ☐Email

Occupation: _______________________________________ Employer Name: ________________________________

Emergency Contact____ Phone___________________________________

How were you referred to this office? ____

HEALTH HISTORY

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? __________________________When? ______________________

How did you respond? ____ Did your previous chiropractor take x-rays? ☐ Yes ☐ No

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

What activities do you do? ☐Running ☐Jogging ☐Weight Training ☐Cycling ☐Yoga ☐Pilates ☐Other (list below):

____

Do you smoke? ☐Yes ☐No How much? ____

Do you drink alcohol? ☐Yes ☐No How much / week? ____

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

Any major past traumatic injuries/surgeries?____

Date of last physical examination:_________________ How would you rate your overall health: ☐Excellent ☐ Good ☐Fair ☐Poor

List any medications your currently taking:____

TERMS OF ACCEPTANCE AND EXPLANATION OF SERVICES

(*Please read and initial*)

When a person seeks chiropractic care, it is essential for both parties to be working towards the same objective. As a Chiropractic office we have one main goal and that is to **detect and correct subluxations with chiropractic adjustments.** It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Subluxations: Routine activities, trauma from accidents, slips and falls, stress, bad posture habits, and many other means can cause subluxations of the spine and/or extremities. Subluxations (otherwise known as, misalignments, joint dysfunctions or fixations) create interference with the normal biomechanical movements of the spine and/or extremities This can cause interference with normal nerve function, decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly.

Chiropractic Adjustments: The specific application of gentle forces applied to the spine and/or extremities to correction subluxation and its effects. Chiropractic adjusting techniques include are, but not limited to, the use of hands, chiropractic drop tables, and instruments. **The goal of the chiropractic adjustment is to corrected subluxations thus restoring normal alignment and function of the body. Our Practice Objective** is to eliminate subluxations using specific chiropractic adjusting combined with rehabilitation procedures

Consultations and Examinations: To determine if you can be helped with chiropractic care, a consultation and examination will be performed before any chiropractic adjustments are performed. If determined that chiropractic care can help your condition/s, specific recommendations with a treatment plan will be discussed.

Patient initials ____________ Date______________

PURPOSE OF THIS VISIT

If you have no symptoms/complaints, and are seeking chiropractic care for wellness adjustments only, please initial here____________

Please fill out completely (one condition at a time) starting with your main health complaint.

(If you have no symptoms and/or complaints, please skip this page)

Main Complaint:____

Is this complaint related to an auto accident / work injury? ☐ Yes ☐ No If so, when: ____________________

When did this condition begin? ______________ How did it begin? ☐ Gradually ☐ Suddenly ☐ Progressive over time

What activities aggravate your symptoms? ______________________________

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

Type of pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐Spasm ☐Numb ☐Tingling ☐ Shooting

Does the pain radiate into your: ☐Arm ☐Leg ☐ Does not radiate Is this condition getting worse? ☐Yes ☐No

How often do you experience these symptoms throughout the day?: ☐100% ☐75% ☐50% ☐25% ☐10% ☐Only with Activity

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? ______________________________

2nd Complaint:____

Is this complaint related to an auto accident / work injury? ☐ Yes ☐No If so, when: ____________________

When did this condition begin? ______________ How did it begin? ☐Gradually ☐ Suddenly ☐ Progressive over time

What activities aggravate your symptoms? ______________________________

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

Type of pain: ☐ Sharp ☐Dull ☐ Ache ☐Burn ☐Throb ☐Spasm ☐Numb ☐Tingling ☐Shooting

Does the pain radiate into your: ☐Arm ☐ Leg ☐ Does not radiate Is this condition getting worse? ☐Yes ☐ No

How often do you experience these symptoms throughout the day?: ☐100% ☐75% ☐50% ☐25% ☐10% ☐Only with Activity

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? ______________________________

3rd Complaint:____

Is this complaint related to an auto accident / work injury? ☐Yes ☐No If so, when: ____________________

When did this condition begin? ______________ How did it begin? ☐ Gradually ☐Suddenly ☐ Progressive over time

What activities aggravate your symptoms? ______________________________

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

Type of pain: ☐Sharp ☐Dull ☐Ache ☐Burn ☐Throb ☐ Spasm ☐Numb ☐ Tingling ☐Shooting

Does the pain radiate into your: ☐Arm ☐ Leg ☐ Does not radiate Is this condition getting worse? ☐ Yes ☐No

How often do you experience these symptoms throughout the day?: ☐100% ☐75% ☐50% ☐25% ☐10% ☐Only with Activity

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? ______________________________

CONSENT TO CARE

I do hereby authorize the doctor at New Hope Chiropractic to administer such care that is necessary for my particular case. This care may include consultation, examination, spinal adjustments and other chiropractic procedures, including various modes of physical therapy necessary for my health care.

Furthermore, I authorize and agree to allow the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, to work with my spine through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration to allow for normal biomechanical motion and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic. I also clearly understand that if I do not follow the doctor's specific recommendations that I will not receive the full health benefits from the programs offered.

I, ____, have read or have had read to me, the above consent. I have also had the opportunity to ask questions about this consent, and by signing below I agree to the above-above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature ____ **Date**________________________(if under 18, Parent Signature)

CONSENT TO EVALUATE AND ADJUST A MINOR/CHILD:

I, _______________________________ being the parent of legal guardian of ________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature____ **Date**____________________________

FINANCIAL RESPONSIBILTY

At the patient's discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan. All patients acknowledge that they are financially responsible for payment in full for all services provided to them. I clearly understand that all insurance coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier, that they are performing these services strictly as a convenience for me. The doctor's office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.

I authorize the assignment of all insurance benefits be directed to New Hope Chiropractic for all services rendered. I authorize New Hope Chiropractic to release all information necessary to secure payment for services rendered to my insurance company. I authorize the use of the signature below on all insurance submissions. I understand any sum of money paid under assignment by any insurance company shall be credited to my account, and I will be personally liable for any and all of the unpaid balance to the doctor. If I receive payment from my insurance company without having paid in full for services rendered, my balance for these services becomes immediately due and payable to New Hope Chiropractic. I certify that this office visit is not related to any personal injury or worker's compensation case that is active or that has not been closed and finalized.

Signature ____**Date**______________________(if under 18, Parent Signature)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

New Hope Chiropractic
11231 W. Hercules Dr. #A
Star, ID 83669

I have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

☒ The right to review the notice prior to signing this consent
☒ The right to object to the use of my health information for directory purposes, and
☒ The right to request restrictions as to how my health information may be used to disclosed to carry out treatment, payment or health care operations.

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Patient Signature: **Date:**

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Name of Patient: ____