

## ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	
AGE:	
MARITAL STATUS:	GENDER:
NUMBER OF CHILDREN & AGES:	
EMPLOYER NAME:	
WORK PHONE:	POSITION TITLE:
LAST 4 OF SOCIAL SECURITY:	

## ABOUT YOUR SPOUSE

SPOUSE NAME:
SPOUSE EMPLOYER:
POSITION TITLE:

## HEALTH HABITS

DO YOU SMOKE? <input type="checkbox"/> YES # PACK/DAY <input type="checkbox"/> NO
DO YOU DRINK ALCOHOL? <input type="checkbox"/> YES # DRINKS/MONTH <input type="checkbox"/> NO
DO YOU DRINK COFFEE, TEA OR SODA? <input type="checkbox"/> YES # CUPS/DAY <input type="checkbox"/> NO
DO YOU EXERCISE REGULARLY? <input type="checkbox"/> YES # DAYS/WEEK <input type="checkbox"/> NO
DO YOU EAT FAST FOOD? <input type="checkbox"/> YES # OF MEALS/WEEK _____ <input type="checkbox"/> NO
ARE YOU AWARE OF THE EFFECTS OF YOUR DIET ON YOUR OVERALL HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO
WOULD YOU LIKE MORE INFORMATION ON THE EFFECTS OF DIET ON YOUR HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU SLEEP WELL? <input type="checkbox"/> YES <input type="checkbox"/> NO # OF HOURS/DAY _____
HOW DO YOU SLEEP? <input type="checkbox"/> BACK <input type="checkbox"/> SIDE <input type="checkbox"/> STOMACH
DO YOU WEAR:
<input type="checkbox"/> HEEL LIFTS <input type="checkbox"/> SOLE LIFTS <input type="checkbox"/> INNER SOLES <input type="checkbox"/> ARCH SUPPORTS

## CHIROPRACTIC HISTORY

WHO May We Thank For Your Referral?
HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (✓ALL THAT APPLY): <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> SIGN <input type="checkbox"/> SOCIAL MEDIA <input type="checkbox"/> COMMUNITY EVENT <input type="checkbox"/> MAILING
HAVE YOU BEEN CHECKED FOR VERTEBRAL SUBLUXATION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I DON'T KNOW
HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, WHAT WAS THE REASON FOR THOSE VISITS?
DOCTOR'S NAME & APPROXIMATE DATE OF YOUR LAST VISIT:
HAS ANY MEMBER OF YOUR FAMILY EVER SEEN A CHIROPRACTOR?

## REASON FOR THIS VISIT

REASON FOR THIS VISIT: <input type="checkbox"/> WELLNESS <input type="checkbox"/> PAIN COMPLAINT <input type="checkbox"/> AUTO/JOB INJURY <input type="checkbox"/> NUTRITION
PLEASE DESCRIBE:
WHAT DATE DID THIS BEGIN?
DID THIS PROBLEM START: <input type="checkbox"/> SUDDENLY <input type="checkbox"/> GRADUALLY <input type="checkbox"/> AFTER AN INJURY
HAS THIS CONCERN: <input type="checkbox"/> GOTTEN WORSE <input type="checkbox"/> BECOME CONSTANT/CHRONIC <input type="checkbox"/> GOTTEN BETTER <input type="checkbox"/> COME AND GONE
WHAT MAKES THE PROBLEM BETTER?
WHAT MAKES THE PROBLEM WORSE?
DOES THIS CONCERN INTERFERE WITH: <input type="checkbox"/> WORK <input type="checkbox"/> SLEEP <input type="checkbox"/> DAILY ROUTINE <input type="checkbox"/> OTHER ACTIVITIES
PLEASE EXPLAIN:
DESCRIBE THE QUALITY OF THE PAIN (SHARP, DULLY ACHE, BURNING, ETC.)
DOES THE PAIN RADIATE? <input type="checkbox"/> YES <input type="checkbox"/> NO TO WHERE?
RATE THE SEVERITY OF THE PAIN (0=NO PAIN, 10=E.R. VISIT):
DOES THE PAIN CHANGE THROUGHOUT THE DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO PLEASE EXPLAIN:
HAVE YOU SEEN OTHER DOCTORS FOR THIS COMPLAINT? <input type="checkbox"/> YES <input type="checkbox"/> NO DOCTOR'S NAME:
TYPE OF TREATMENT:
RESULTS: <input type="checkbox"/> GOOD <input type="checkbox"/> BAD <input type="checkbox"/> INDIFFERENT

## CHIROPRACTIC KNOWLEDGE

ARE YOU AWARE THAT NOT ALL CHIROPRACTIC CARE IS THE SAME AND NOT EVERY CHIROPRACTIC APPROACH IS SPECIFIC?  YES  NO

ARE YOU AWARE THE CHIROPRACTORS WORK WITH THE NERVOUS SYSTEM?  YES  NO

ARE YOU AWARE THAT THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL BODY SYSTEMS AND FUNCTIONS?  YES  NO

ARE YOU AWARE THAT SYMPTOMS OFTEN TIMES ARE THE LAST TO SHOW UP?  YES  NO

DID YOU KNOW THAT YOU CAN HAVE LOSS OF FUNCTION WITHOUT EXPERIENCING PAIN?  YES  NO

DID YOU KNOW THAT CHIROPRACTIC CARE IS SAFE DURING PREGNANCY AND CAN HELP TO KEEP THE BABY IN OPTIMAL POSITION FOR LABOR AND DELIVERY?  YES  NO

DID YOU KNOW THAT CHIROPRACTIC CARE CAN HELP CHILDREN FUNCTION OPTIMALLY TOO?  YES  NO

*Many problems and health challenges can start as structural shifts that decrease normal function and result in secondary conditions like pain and muscle spasm. Please CIRCLE below any concerns you are experiencing now as well as in the past. Feel free to list any other concerns or health challenges you may be having under 'other'.*

## OTHER SYMPTOMS

Sore Throat  
Stiff Neck  
Radiating Arm Pain  
Hand/Finger Numbness  
Asthma  
Allergies  
High Blood Pressure  
Heart Conditions



Headaches  
Migraines  
Dizziness  
Sinus Problems  
Allergies  
Fatigue  
Head Colds  
Vision Problems  
Difficulty Concentrating  
Hearing Problems

Middle Back Pain  
Congestion  
Difficulty Breathing  
Bronchitis  
Pneumonia  
Gallbladder Conditions  
Stomach Problems  
Ulcers  
Gastritis  
Kidney Problems

Constipation  
Colitis  
Diarrhea  
Gas Pain  
Irritable Bowel  
Bladder Problems  
Menstrual Problems  
Low Back Pain  
Pain or Numbness in legs  
Reproductive Problems

**OTHER:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## GOALS FOR YOUR CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your Doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. PLEASE PICK ONE.

- As Needed:** Symptomatic relief of pain or discomfort.
- Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom or pain.
- Maintenance/ Wellness:** Prevent future problems from occurring and old ones from returning.
- I want the Doctor to select the type of care for my condition.*

## PERSONAL HISTORY

DO YOU HAVE ANY DIAGNOSED DISEASES (HEART DISEASE, DIABETES, ETC.)?  YES  NO  
PLEASE LIST:

DO YOU HAVE A HISTORY OF CAR ACCIDENTS, BROKEN BONES, FALLS OR OTHER TRAUMAS?  YES  NO  
PLEASE LIST:

HAVE YOU HAD ANY SURGERIES?  YES  NO  
PLEASE LIST WITH APPROXIMATE DATES:

ARE YOU CURRENTLY EXPERIENCING ANY MAJOR STRESS IN YOUR LIFE OTHERWISE UNLISTED ON THIS FORM?  YES  NO

## FAMILY HISTORY

PLEASE MARK ANY CONDITIONS YOUR FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

M = MOTHER F=FATHER S=SIBLINGS G = GRANDPARENTS

CANCER: TYPE \_\_\_\_\_  
 M  F  S  G

DEPRESSION  
 M  F  S  G

DIABETES  
 M  F  S  G

HEART DISEASE  
 M  F  S  G

LIVER DISEASE  
 M  F  S  G

HIGH CHOLESTEROL  
 M  F  S  G

HIGH BLOOD PRESSURE  
 M  F  S  G

LUNG PROBLEMS  
 M  F  S  G

SEIZURES  
 M  F  S  G

NECK PROBLEMS  
 M  F  S  G

BACK PROBLEMS  
 M  F  S  G

SCOLIOSIS  
 M  F  S  G

OSTEOARTHRITIS  
 M  F  S  G

RHEUMATOID ARTHRITIS  
 M  F  S  G

AUTOIMMUNE DISEASES  
 M  F  S  G

OTHER: \_\_\_\_\_

## ABOUT YOUR PREGNANCY

Is this your first pregnancy?  YES  NO How many pregnancies have you had: \_\_\_  
Any complications with previous pregnancies?

Was this pregnancy planned?  YES  NO  
IF YES, HOW FAR ALONG? \_\_\_\_\_ WEEKS  
DUE DATE: \_\_\_\_\_

Who is your primary caregiver?  OBGYN  GP  MIDWIFE NAME: \_\_\_\_\_  
DELIVERY LOCATION?  HOSPITAL  HOME  BIRTHING CENTER  OTHER  
ANY SPECIAL BIRTH ARRANGEMENTS(C-SECTION, WATER BIRTH, ETC.)  
PLANNED?

HAVE YOU HAD ANY GENETIC TESTING/?  YES  NO  
DATES AND REASONS: \_\_\_\_\_  
DO YOU HAVE BLOOD PRESSURE CONCERNS?  YES  NO  
ARE YOU PLANNING TO BREASTFEED?  YES  NO

HAVE YOU NOTICED:  
SWELLING IN ARMS AND LEGS  YES  NO  
BACK PAIN  YES  NO IF SO WHERE: \_\_\_\_\_  
NECK PAIN  YES  NO DIZZINESS/NAUSEA  YES  NO  
DIGESTIVE COMPLAINTS  YES  NO  
HEARTBURN/CONSTIPATION  YES  NO  
HEADACHES  YES  NO  
PAIN RADIATING DOWN LEGS  YES  NO  
HEART PALPATATIONS  YES  NO  
ANY OTHER CONCERNS? \_\_\_\_\_

## PHYSICAL STRESSES

ANY SIGNIFICANT INJURIES IN CHILDHOOD OR ADULTHOOD?

ANY HOSPITAL VISITS  YES  NO

EXPLAIN: \_\_\_\_\_

ANY SURGERIES?  YES  NO

LIST: \_\_\_\_\_

ANY FRACTURES OR DISLOCATIONS?  YES  NO

LIST: \_\_\_\_\_

ARE YOU IN PROLONGED POSTURES (EX: SITTING, LIFTING, ETC)

YES  NO EXPLAIN: \_\_\_\_\_

ANY HOBBIES THAT ARE PHYSICALLY STRENUOUS?  YES  NO

EXPLAIN: \_\_\_\_\_

WHAT IS YOUR USUAL EXERCISE ROUTINE:

ANY VEHICLE ACCIDENTS?  YES  NO

WHAT HAPPENED AND WHEN?

## CHEMICAL STRESSES

ARE YOU TAKING ANY MEDICATIONS?  YES  NO  
IF YES LIST BELOW

ARE YOU TAKING ANY SUPPLEMENTS?  YES  NO  
IF YES LIST BELOW

DO YOU DRINK BOTTLED WATER?  YES  NO  
ARE YOU EXPOSED TO ANY OF THE FOLLOWING:  
 POLLUTANTS  STRONG SMELLS  CHEMICALS  AEROSOLS  
DO YOU EAT ORGANIC  YES  NO  
DO YOU USE NATURAL/ENVIRONMENTALLY FRIENDLY PRODUCTS?  
 YES  NO  
DO YOU DRINK, BATHE OR SHOWER IN CHLORINATED WATER?  
 YES  NO

## EMOTIONAL STRESSES

RANK FROM 1 (MINIMAL) TO 10 (EXTREME):

LIFE IN GENERAL \_\_\_\_\_ WORK AND CAREER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

FINANCES \_\_\_\_\_ TIME MANAGEMENT \_\_\_\_\_ THIS PREGNANCY \_\_\_\_\_

HEALTH AND WELL BEING \_\_\_\_\_ QUALITY OF SLEEP \_\_\_\_\_ HOBBIES \_\_\_\_\_

PLEASE LIST ANY SIGNIFICANT OR ONGOING STRESS:

DO YOU PRACTICE ANY FORM OF RELAXATION?  YES  NO

EXPLAIN:

ANY ADDITIONAL CONCERNS:

ARE YOU INTERESTED IN LEARNING STRESS REDUCING PRACTICES?

YES  NO

THANK YOU FOR CHOOSING NEW SPRING CHIROPRACTIC AND HELPING US CONTINUE OUR MISSION  
*TO Help Families Experience True Health!*

**INFORMED CONSENT FOR CHIROPRACTIC TREATMENT**

**REGARDING:** Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at [New Spring Chiropractic](#), have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ Patient or Authorized Person's Signature	____/____/____ Date	_____ Witness Initials
_____ Doctor's Signature	____/____/____ Date	

**NOTICE OF PRIVACY POLICY**

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

*I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

*I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed. I also allow use of my personal email address for office communication.*

**To receive text and/or email appointment reminders, initial here \_\_\_\_\_**

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: