RESTORE
CHIROPRACTIC & WELLNESS

NEW PATIENT INFORMATION

PATIENT INFORMATION

Full Name:			
Mailing address:			
City:	State:	Zip:	
Birth Date:	Sex: ○Male ○Female	Height: ft. in.	Weight: lbs.
Cell Phone:	Email:		
How did you hear about us?			
Have you seen a chiropractor before? ○Yes ○No When?			

CURRENT HEALTH CONDITIONS

What is your major complaint that brings you to the office today?

Do you have a secondary complaint?

Date the major condition first began: _____
Have you experienced this same issue in the past?
○Yes ○No When?

What makes it better?
What makes it worse?

Have you received other care for this problem? ○Yes ○No
If yes, please explain:

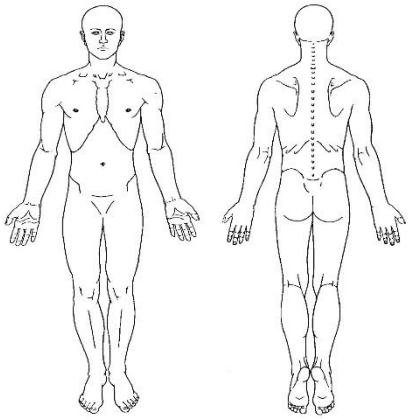
How did the problem start? ○Suddenly ○Gradually ○Post Injury

Was there an action that created the injury? (i.e. Lifting, twisting, bending) Please explain: _____

_____

Place the corresponding letter on the body area where pain occurs

D Dull Nagging Ache
S Sharp / Stabbing
N Numbness / Tingling
B Burning



Is this condition: ○Getting worse ○Improving ○Staying the same

How often do you experience symptoms? ○Constantly ○Frequently ○Intermittently ○Occasionally

On a scale of 1-10 how intense are your symptoms? Circle one: Not intense 1 2 3 4 5 6 7 8 9 10 Unbearable

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MEDICAL HISTORY

List all medications you are taking now, including over the counter medications and supplements:

Allergies? Please list:

Have you been x-rayed or received an MRI, CAT scan in the last year? ○Yes ○No

Additional Complaints

Please check all additional complaints that you have at this time:

○ **Abnormal** weight gain or loss	○ Stroke	○ Neck pain
○ Dizziness	○ Heart attack	○ Mid/upper back pain
○ Headaches/Migraines	○ High blood pressure	○ Low back pain
○ Loss of concentration	○ Loss of balance	○ Elbow/upper arm pain
○ Arthritis	○ Ringing in ears	○ Knee/lower leg pain
○ Asthma	○ Loss of bladder control	○ Wrist pain
○ Chest pains	○ Frequent urination	○ Ankle/foot pain
○ Depression	○ Sinus trouble	○ Shoulder pain
○ Anxiety	○ Irritable	○ Hip/upper leg pain
○ Insomnia	○ Fatigue	○ Other: _____

TRAUMAS: Physical Injury History

Have you had any significant falls, surgeries, or other injuries as an adult? ○Yes ○No
If yes, please explain:

Notable childhood injuries? Please explain:

Any auto accidents? Please list approx. date and severity:

Any sports related traumas? Please explain:

FAMILY HISTORY

Please list any significant family history of illness and their relation to you: i.e. cancers, high blood pressure, diabetes, stroke, high cholesterol, depression, anxiety

1. _____
2. _____
3. _____

YOUR HEALTH GOALS

List your top three health goals:

1. _____
2. _____
3. _____

DOCTOR'S NOTES

_____

_____

_____

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INFORMED CONSENT

I hereby authorize the doctor at Restore Chiropractic & Wellness to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions undisclosed to them.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Restore Chiropractic & Wellness responsible for any errors or omissions that I may have made in the completion of this form. I understand that if any new medical conditions occur I am to notify the doctor at the start of my appointment.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any question concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

_____ _____

Signature **Date**

AUTHORIZATION & ASSIGNMENT

I authorize Restore Chiropractic & Wellness to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Restore Chiropractic & Wellness authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

_____ _____

Signature **Date**

OFFICE POLICIES

Please initial each box below (If minor, parent/guardian initial)

_____ Initial	**Financial Policy** – By signing below, I understand that I am responsible for any copay, coinsurance, or deductible due at the time of service and am responsible for the complete charge or remaining balance of any services that my insurance determines as noncovered. I understand that not all services are covered by all insurances and that non covered services will invoke the out of pocket cost and are due at the time of service. I understand that any balances due after 120 days from the initial date of service will be sent to collections, unless a payment plan has been agreed upon. I agree that I will be responsible for any collection agency or attorney fees incurred.
_____ Initial	**Insurance Policy** – As a courtesy to our patients we will look up your insurance information at your initial appointment. I agree that I am responsible for providing up to date insurance information at the time of service. I understand that if I do not provide accurate insurance information, I will be charged the out of pocket fees. I understand it is my responsibility to notify RCW if I have a Health Reimbursement Account, as RCW is unable to verify this information which can therefore lead to inaccurate charges.
_____ Initial	**Appointment Cancellation/No Show Policy** – I acknowledge that failure to be present for my scheduled appointment without prior notice will result in a No Show fee of $35. I understand that repetitive missed appointments without notification may lead to termination of care.

_____ _____ _____

Print Full Name **Signature** **Date**