Patient Name: _____ HR#_____

CHIROPRACTIC NEW PATIENT APPLICATION

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____

D.O.B. _____/_____/_____ Gender: Male Female BP:_____/_____ Height:_____ Weight:_____

Address: _____ City: _____ State/Providence:_____

Zip Code: _____ ****Preferred Method of Contact (please circle): Text Call Email*

Telephone: (_____)_____ Email: _____@_____

Names of Spouse/Children: _____

Occupation: _____ **Referred by a friend? Who can we thank?* _____

HEALTH PROFILE

Please select the statement that best describes your reason for seeking out chiropractic care.

- ☐ I am seeking WELLNESS CARE.
- ☐ I am seeking CHIROPRACTIC CARE FOR THE FOLLOWING SYMPTOMS

Health Concerns:	**Severity of Condition:**	**Month/Year of Onset:**	**Due to Injury?**
1. _____	1 2 3 4 5 6 7 8 9 10	_____	yes / no
2. _____	1 2 3 4 5 6 7 8 9 10	_____	yes / no
3. _____	1 2 3 4 5 6 7 8 9 10	_____	yes / no
4. _____	1 2 3 4 5 6 7 8 9 10	_____	yes / no

(No Pain) <—> (Painful)

Since your symptom(s) began, they are…

- ☐ Getting Better
- ☐ Staying the Same
- ☐ Getting Worse

Do any activities make your symptoms worse?

List here: _____

_____

_____

Do any activities make your symptoms better?

List here: _____

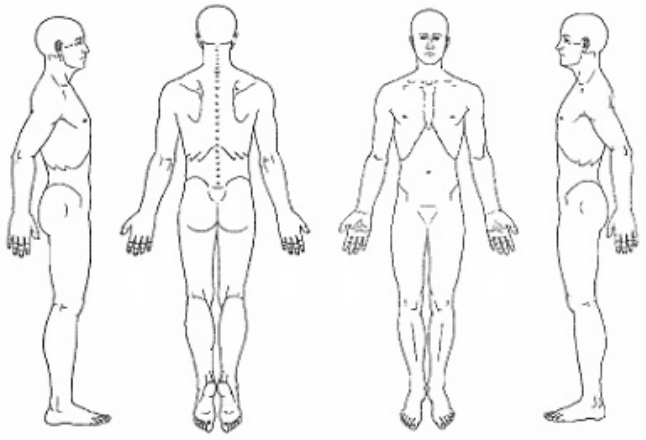
_____

_____

When are your symptoms most noticeable/painful?

- ☐ When Active
- ☐ When Sitting
- ☐ When Lying Down
- ☐ Constantly
- ☐ Other: _____

_____



On the diagram above, mark the areas of the body where you experience any of the following symptoms:

A = Ache(s) **N = Numbness** **S = Stabbing Pain**
B= Burning **P = Pressure** **T = Tingling**
F = Stiffness **R = Radiating**

Do you have any known allergies? (*Seasonal or otherwise)* _____

Have you ever fractured or broken, any bones? If yes, describe: _____

Have you ever had a serious illness and/or health emergency? If yes, explain: _____

Have you been diagnosed with any genetic disorders and/or disabilities? If yes, describe: _____

_____

Reviewed by: _____ on _____/_____/_____

Patient Name: _____ HR#_____

HEALTH PROFILE (CONTINUED)

Please select any of the following conditions that you've experienced prior to visiting our clinic.

- ☐ Allergies
- ☐ Anxiety
- ☐ Blood Sugar Issues
- ☐ Cold Hands/Feet
- ☐ Cold Sweats
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty Focusing
- ☐ Dizziness
- ☐ Dry Eyes
- ☐ Dry Skin
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever(s)
- ☐ Frequent Illness
- ☐ Headaches
- ☐ Heartburn
- ☐ Hormone Imbalance
- ☐ Hot flashes
- ☐ Irritability
- ☐ Insomnia
- ☐ Light Sensitivity
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Menstrual Irregularity
- ☐ Menstrual Pain
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Pins/Needles in Arms
- ☐ Pins/Needles in Legs
- ☐ Poor Memory
- ☐ Ringing in Ears
- ☐ Sinus Issues
- ☐ Stiff Neck
- ☐ Ulcers
- ☐ Upset Stomach
- ☐ Urinary Problems

Please list any major or minor operations that you have had below.

	Surgery Type:	Month/Year:	Due to Injury?	Medical Facility/Surgeon Name
1.	_____	_____	yes / no	_____
2.	_____	_____	yes / no	_____
3.	_____	_____	yes / no	_____
4.	_____	_____	yes / no	_____
5.				

Please list any medications that you are currently taking. (*including any over-the-counter (OTC) medications*)

	Medication Name	Reason for Taking
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Do you smoke tobacco?	yes	no	socially
Do you consume alcohol?	yes	no	socially
Do you partake in recreational drug use?	yes	no	socially

Please select any of the following goals that you would like to reach while receiving care in our clinic.

PERSONAL HEALTH GOALS

- ☐ Relieve Pain
- ☐ Relieve Discomfort
- ☐ Restore Function
- ☐ Increase Energy
- ☐ Improve Posture
- ☐ Improve General Mobility
- ☐ Improve Sleeping Habits
- ☐ Pregnancy Care
- ☐ Fertility Support
- ☐ Attend Health Courses
- ☐ Reduce Medication(s)
- ☐ Improve Diet/Nutrition
- ☐ Improve Focus/Attention
- ☐ Increase Confidence
- ☐ Improve Emotional Health
- ☐ Strengthen Immune System
- ☐ Maintain Healthy Body Weight
- ☐ Improve an Acute Condition
- ☐ Other: _____

Reviewed by: _____ on _____/_____/_____

Patient Name: _____ HR#_____

INSURANCE INFORMATION

Patient Name: _____ Relationship to Subscriber: ■ Self ■ Spouse ■ Child

Patient Date of Birth: _____/_____/_____ Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth _____/_____/_____

Secondary Insurance Company? ***If yes, please provide a copy of your secondary insurance card.***

PRIVACY NOTICE

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payments, 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 via telephone, email, and or text (SMS) message for future appointment reminders, announcements, and to inform you about our practice and its staff. I authorize the use of my full name for the purpose of greeting me, announcing me into a room, or around the office.

Exodus Chiropractic reserves the right to change this privacy policy as allowed by law and to make the new notice apply to health information already received as well as any information received in the future. A copy of our current notice is available upon request. This notice will display the effective date.

I understand that, under the Health Insurance Portability 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, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understood 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 disclosed.

INFORMED CONSENT

I hereby consent doctors and staff at Exodus Chiropractic permission and authority to care for me. At Exodus Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctor / clinic will not be held responsible for any pre-existing medical conditions. I certify that the above information is correct to the best of my knowledge. I will not hold the staff at Exodus Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic tests, diagnosis, and adjustments are very safe, very beneficial any rarely cause any risk. In rare cases, underlying physical defects, deformities or pathologies may make the practice member prone to injury. It is the practice member's responsibility to make it known to the doctor. I understand that following the doctor's recommended care plan is essential to maximizing my healing and reaching optimal health through chiropractic care. Furthermore, any questions that I have regarding chiropractic care will be explained to me upon my request.

FINANCIAL POLICY

By my signature below, I recognize that I am financially responsible for all services rendered to me regardless of insurance benefits. I further understand that any health insurance policy is an arrangement between me and my insurance carrier and that I may be required to pay for some or all the fees charged to my account.I authorize Exodus Chiropractic 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. It is the policy of Exodus Chiropractic that all charges will be paid by cash, check, or credit card at the time services are rendered. If you have any questions about our financial policies please ask our administrative manager. If you need to make any special arrangements, please ask.

Patient Signature: _____ Date: _____/_____/_____

Reviewed by: _____ on _____/_____/_____

Patient Name: _____ HR#_____

X-RAY AUTHORIZATION

(ONLY IF DOCTOR DEEMS NECESSARY)

Specific postural x-rays may be necessary for the identification of the location, type, and severity of vertebral subluxation, as well as for the diagnosis and identification of latent or dangerous conditions requiring medical attention. X-rays may be used to show progress after a period of recommended chiropractic care. **At your request you can receive a copy of your x-rays on a DVD-ROM for a fee of $20.00.** *By my signature below, I authorize Exodus Chiropractic to perform diagnostic imaging of me.*

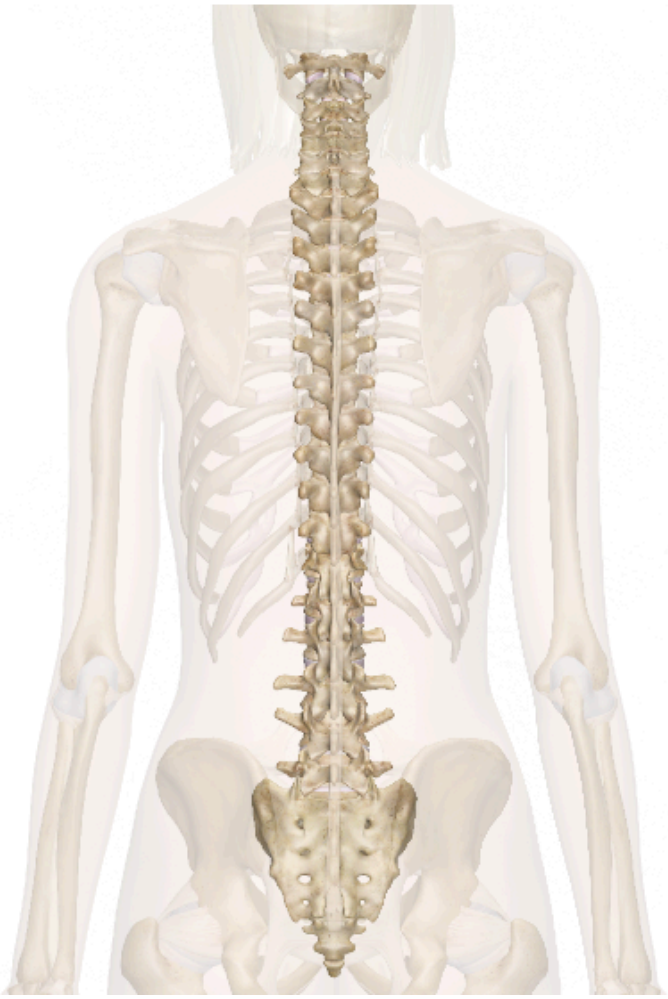
FEMALES ONLY: ☐ To my best knowledge, there is no chance that I am pregnant at this time.

☐ I know or believe that I may be pregnant at this time and therefore ***DO NOT*** authorize digital x-rays.

Patient's Printed Name: _____ *Date of Birth:* _____/_____/_____

Signature: _____

**** FOR OFFICE USE ONLY ****



C1	L / R / BILATERAL	☐ Edema
C2	L / R / BILATERAL	☐ Edema
C3	L / R / BILATERAL	☐ Edema
C4	L / R / BILATERAL	☐ Edema
C5	L / R / BILATERAL	☐ Edema
C6	L / R / BILATERAL	☐ Edema
C7	L / R / BILATERAL	☐ Edema
T1	L / R / BILATERAL	☐ Edema
T2	L / R / BILATERAL	☐ Edema
T3	L / R / BILATERAL	☐ Edema
T4	L / R / BILATERAL	☐ Edema
T5	L / R / BILATERAL	☐ Edema
T6	L / R / BILATERAL	☐ Edema
T7	L / R / BILATERAL	☐ Edema
T8	L / R / BILATERAL	☐ Edema
T9	L / R / BILATERAL	☐ Edema
T10	L / R / BILATERAL	☐ Edema
T11	L / R / BILATERAL	☐ Edema
T12	L / R / BILATERAL	☐ Edema
L1	L / R / BILATERAL	☐ Edema
L2	L / R / BILATERAL	☐ Edema
L3	L / R / BILATERAL	☐ Edema
L4	L / R / BILATERAL	☐ Edema
L5	L / R / BILATERAL	☐ Edema

Anterior Head Carriage	High Hip	High Shoulder	Foot Flare	Bilateral Weight:
_____	L _____	L _____	L _____	L _____
_____	R _____	R _____	R _____	R _____

Reviewed by: _____ on _____/_____/_____