New Life Chiropractic LLC.

Confidential Health Report

Personal Information		
Name (Legal)		Preferred/Nickname
Social Security No	Gender	Date of Birth
Address		
City, State, Zip		Referred By
Home Phone	Work Phone	Cell Phone
E-mail		
Marital Status	Spouse's Name	
Occupation		Employer
Primary Insurance		Secondary
Insured's Social Security No		Insured's Date of Birth
Person financially responsible for account		Parent/Guardian
Name of person(s) we can discuss your care/account with (name, address, phone)		
Are you here for wellness care or symptoms?		
Have you been treated by another physician for this condition?		
Doctor's Name(s)		

History
List vitamins/supplements taking:
How often do you exercise? On a scale of 0 to 100, how healthy do you think you are? 0--------25---------50--------75--------100
Do you smoke? Y / N Do you drink alcohol? Y / N Do you drink coffee, tea or soda? Y / N
List ALL accidents, falls, or traumas that you have had (include car accidents and injuries sustained).
Do you have any specific illnesses?
What surgeries have you had and when?
What medications are you taking and what is their intended use?
What allergies do you have?
What conditions do your parents suffer from?
What is the cause and age of death of parents or siblings?

List the names, ages, and health conditions of your children		
	Age:	
	Age:	
	Age:	
Do you think your children would benefit from chiropractic care?		

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

____ Appendicitis	____ Measles	____ Scarlet Fever	____ Venereal Disease
____ Chicken Pox	____ Mononucleosis	____ Sinus Infections	____ Whooping Cough
____ Cold Sores	____ Mumps	____ Tonsillitis	___ Other _____
____ Croup	____ Polio	____ Tuberculosis	_____
____ Diphtheria	____ Rheumatic Fever	____ Typhoid Fever	

CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE **NOW (N)** OR THE **PAST (P)**:

N	P	*GENERAL:*
____	____	Autoimmune
____	____	Cancer ...if so, what type:_____
____	____	Frequent Colds/Flus
____	____	Headaches
____	____	Increased/Decreased Appetite
____	____	Migraines
____	____	Loss of Sleep or Increased Sleep
____	____	Loss of Weight or Increased Weight
____	____	Tremors or Shaking
____	____	Scoliosis
		BEHAVIORAL
____	____	Abuse/Neglect
____	____	Addiction
____	____	Anxiety
____	____	Depression
____	____	Eating Disorder
____	____	Hyperactivity
		CARDIOVASCULAR:
____	____	Arrhythmia
____	____	Anemia/Iron Deficiency
____	____	Arteriosclerosis
____	____	Cold Hand/Feet
____	____	Heart Surgery/Pacemaker
____	____	Heart Disease
____	____	High Blood Pressure
____	____	Low Blood Pressure
____	____	Rapid/Slow Beating Heart
____	____	Stroke
____	____	Swollen Ankles
____	____	Valve or Heart Disorders
____	____	Varicose Veins
		E.E.N.T.:
____	____	Deafness/Difficulty Hearing
____	____	Dizziness/ Vertigo
____	____	Ear Infections
____	____	Hay Fever/Seasonal Allergies
____	____	Hoarseness
____	____	Nosebleeds
____	____	Sore Throat

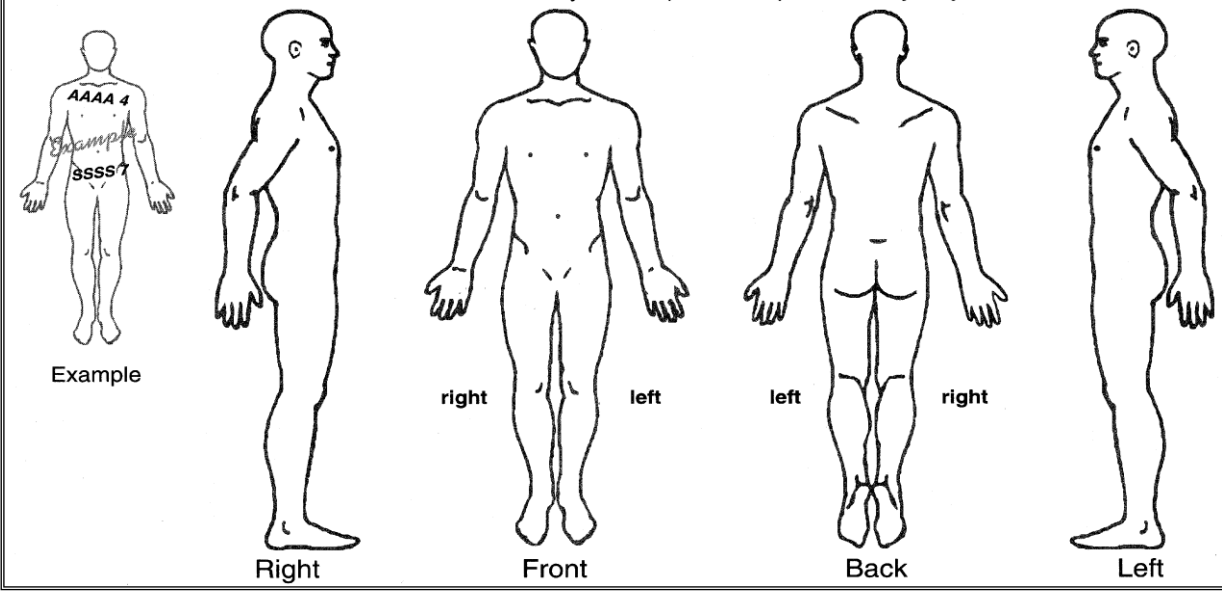
N	P	*GASTRO-INTESTINAL*:
____	____	Acid Reflux/Difficult Digestion
____	____	Belching/Gas
____	____	Constipation
____	____	Diarrhea
____	____	Gall Bladder Attacks/Irritation
____	____	Hernia
____	____	Jaundice
____	____	Liver Conditions
____	____	Ulcer/Colitis
		ENDOCRINOLOGY
____	____	Diabetes
____	____	Hypoglycemia
____	____	Thyroid deficiency/Goiter
____	____	Osteopenia/Osteoporosis
		NEUROLOGICAL
____	____	Epilepsy/Seizures
____	____	Fibromyalgia
____	____	Multiple Sclerosis
		RESPIRATORY:
____	____	Asthma
____	____	Bronchitis
____	____	Chest Pain
____	____	Chronic Cough
____	____	Difficulty Breathing
____	____	Emphysema
____	____	Pleurisy
____	____	Pneumonia
____	____	Wheezing
		GENITO-URINARY:
____	____	Bed Wetting
____	____	Blood/Pus in Urine
____	____	Frequent Urination
____	____	Inability to Control Urine
____	____	Painful Urination
____	____	Prostate Trouble
		FOR WOMEN ONLY:
____	____	Cramps or Backache
____	____	Excessive Flow / Discharge

SKIN:	____ ____ Hot Flashes (Menopausal Symptoms)
____ ____ Acne	____ ____ Irregular Cycle / Painful Menses
____ ____ Bruise Easily	____ ____ Miscarriage
____ ____ Hives or Allergy	____ ____ Infertility
____ ____ Itching or Rashes	
____ ____ Eczema	**ARE YOU PREGNANT?** YES____ NO____
____ ____ Psoriasis	

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description → Numbness Pins & Needles Burning Aching Stabbing
Symbol → NNNN PPPP BBBB AAAA SSSS

◯ Circle any area of pain not represented by a symbol.



Complaint Form
What is your primary complaint?
When did it start?
What were you doing?
Where is the symptom?
Where does it travel?
Describe the symptom Sharp Dull Aching Burning Numb Throbbing Radiating
How severe is it? 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
How often do you have it? Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%
What makes it better?
What makes it worse?
What movements are difficult?
What have you done for this already?
What activities can you NOT do because of this?
Check the areas where you have experienced pain/numbness before: __ Face __ Neck __ Jaw/TMJ __Upper Back __Shoulders __ Elbows __ Hands/Wrists __ Lower Back __Hips __ Legs/Knees __Feet __Sciatica

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Office Use Only:
Score _____
% _____

Functional Rating Index

In order to properly assess your condition, we must understand how your **neck and/or back problems** have affected your ability to manage every day activities. For each item below, **please circle the answer which most closely describes your condition today**.

Name: _____ **Date:** _____

1. Pain Intensity	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. Sleeping	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. Personal Care (washing, dressing, etc.)	No pain, no restrictions (0)	Mild pain, no restrictions (1)	Moderate pain, need to go slowly (2)	Moderate pain, need some assistance (3)	Severe pain, need 100% assistance (4)
4. Travel (driving, riding in vehicle, etc.)	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. Work	Can do normal work plus unlimited extra work (0)	Can do normal work, no extra work (1)	Can do 50% of normal work (2)	Can do 25% of normal work (3)	Cannot work (4)
6. Recreation	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. Frequency of pain	No pain (0)	Occasional pain, 25% of day (1)	Intermittent pain, 50% of day (2)	Frequent pain, 75% of day (3)	Constant pain, 100% of day (4)
8. Lifting	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. Walking	No pain, any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain, any distance (4)
10. Standing	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social wellbeing, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature Relationship to Patient Date

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature Relationship to Patient Date

X-RAY CONSENT

Please check here if there is any possibility you are pregnant: _____

This is to certify that Dr. Daniels has my permission to order/ perform an X-ray evaluation when I am no longer pregnant.

Signature Relationship to Patient Date

If you are not pregnant or male, please sign below:

This is to certify that Dr. Daniels has my permission to order/perform an X-ray evaluation at the time of this exam. To the best of my knowledge I am not pregnant and I have been advised that x-ray can be hazardous to an unborn child. If female, date of last menstrual period: _____.

Signature Relationship to Patient Date

INSURANCE

Your insurance company will only pay for services that they determine are medically necessary. As a patient you must understand that some or all services provided for your care might not be covered by your contract benefits. You as a patient are liable for all charges that your plan does not cover. I have been notified by my physician that my insurance may not cover all the services provided for my care. If payment is denied for these services, I agree to be personally and fully responsible for payment. Any co-pay, coinsurance, or deductible is due at the time of service.

Signature Relationship to Patient Date

PERSONAL FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Daniels will assist in preparing any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and 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 to me will be immediately due and payable.

Signature Relationship to Patient Date