Onsite Chiropractic Care New Patient Form

Personal Information (Please Print)

Date _____

Name _____ Cell Phone_____
Address _____City/ST_____ Zip_____

Age _____ Birthdate _____/_____/_____Sex: M F Email:_____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Data

Insurance Name: _____Insurance Member ID #_____
Group#_____

If Spouse's Insurance their name: _____ Their Birthdate_____/_____/_____
Their Ins ID#_____ Their Group #_____

Patient PIN/Cell #:_____

Informed Consent to Chiropractic Spinal Manipulation, Supportive Care & Consent for Treatment

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on myself (of on the patient named below for whom I am legally responsible) by Diana DeLaRosa, D.C., and /or any other licensed doctors of chiropractic who now or in the future work for/with Dr. DeLaRosa. I have had the opportunity to discuss with Dr. DeLaRosa the nature and purpose of chiropractic adjustments and other procedures, and I understand and am 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, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns.

I understand and comprehend all such risks and complaints. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I understand that I am responsible for all professional services rendered to me. Furthermore, I understand the Federal Government has deemed it mandatory to notify my doctor or any other party or insurance company who may be responsible for reimbursement for my treatment. I also authorize that I am liable for any financial arrangements that will be made.

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

Patient Signature: _____ **Date:** _____**Printed Name:** _____

Acknowledgement of Receipt of Privacy Practices

I have been given a copy of this facility's "Notice of Privacy Practices", which describes how my health information is used and shared. I understand that Onsite Chiropractic has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Privacy Officer of this facility at any time.

As required by the Privacy Regulations, _____from Onsite Chiropractic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

Requests:

- I want to file a "Request for Restriction" of my protected health information.
- I want to file a "Request for Alternative Communications" of my protected health information.
- I want to object to the following in the "Notice of Privacy Practices":

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Patient Signature: _____ **Date**: _____**Printed Name**: _____

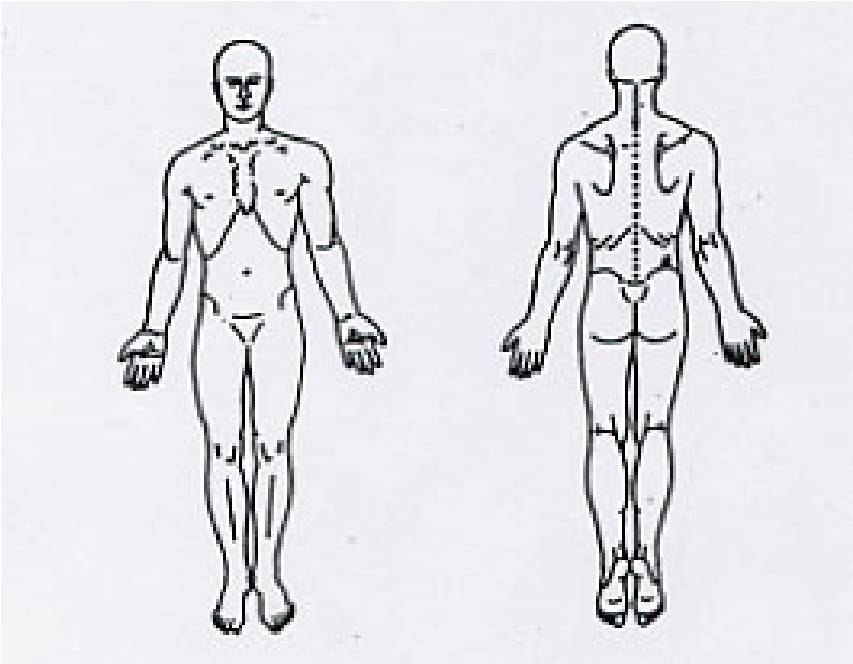
FOR OFFICE USE ONLY

Received By:_____Date:_____

Diagnosis:1)_____2)_____3)_____4)_____
5)_____6)_____7)_____8)_____

Charges: 1)_____2)_____3)_____ 4)_____
5)_____6)_____7)_____ 8)_____

Please shade on drawing area of pain and label with codes:



P- Pain N-Numbness

ST-Stiffness T-Tingling

NOTES:

Reason for your Visit: (please circle) work auto accident chronic problem trauma other

Describe the pain and its location:

_____

_____

_____

Date of accident/injury, or when condition began: _____

Has the pain/problem: (circle) Improved Worsened Not changed Constant

Intermittent Daily Weekly _____

Is this condition interfering with your: (circle) Work Sleep Daily Routine Exercise

What activity bothers you most? _____

Have you been treated by another doctor for this condition? No Yes, _____

Complicating Factors: (circle all that apply)

Decreased flexibility Predisposition of repetitive strains Postural faults (slumped shoulders, slouch)

On/off same pain > 10 yrs Radiating pain Poor fitness Structural asymmetry (short leg)

4 episodes or > of same pain Severe pain (8-10 on pain scale) Impaired Coordination

Your Health History

Please list any medications, even OTC that you are presently taking:_____

_____

Please list any medications that you are allergic to:

_____

(circle "C" if the problem is a *current* one and "P" if you've had the problem in the *past*)

General
C P Allergy
C P Convulsions
C P Dizziness
C P Fainting
C P Headaches
C P Sudden Wt.Loss

Muscle & Joint
C P Arthritis
C P Bursitis
C P Low Back Pain
C P Neck Pain
C P Shoulder Pain
C P Spinal Curvature

Eyes, Ears, Nose & Throat
C P Deafness
C P Ear-ache
C P Failing Vision
C P Nosebleeds
C P Sinus Infections
C P Thyroid Problems

Gastrointestinal
C P Colon Probs.
C P Constipation
C P Diarrhea
C P Gall Bladder
C P Liver Probs.
C P Hernia
C P Nausea
C P Vomiting

Respiratory
C P Asthma
C P Chest Pain
C P Spitting up Blood

Pain or Numbness in:
C P Shoulders/Arms
C P Elbows/Hands
C P Hips/Legs
C P Ankles/Knees/Feet

Skin Problems
C P Bruise Easily
C P Hives or Allergy
C P Skin Rash
C P Acne

Other
C P Alcoholism
C P Anemia
C P Cancer
C P Measles
C P Stroke
C P Rheum.Fvr.
C P HIV/AIDS

Cardio-Vascular
C P Hard. Of Arteries
C P High Blood Pressure
C P Low Bld. Pressure
C P Rapid/Slow Heartbt.
C P Swelling of Ankles
C P Arrhythmia

Genito-Urinary
C P Bedwetting
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Trouble
C P Kidney Stones

For Women Only
C P Cramps/ Backache w/cycle
C P Excessive Menstrual Flow
C P Irregular Cycle
C P Lumps in Breast
C P Pain w/ intercourse
C P Pelvic Inflammatory Disease

Injuries/Surgeries you have had: Description Date
Surgeries:

_____

Motor Vehicle Accidents/Falls:

_____

Broken Bones/Dislocations:

_____

Past Family History

(many health problems are the result of familial tendencies; thus, information about your family members will give us a better picture of your total health)

Family Member Illness Age or Age Died Cause of Death___

Father_____

Mother_____

Other_____

Social History

Do you smoke? Yes_____ No _____
If yes, approximately how many cigarettes per day? _____ for how long? _____
Do you exercise regularly? Yes_____ No_____ If yes, daily? _____3x/week_____ 1x/week_____

How? _____

Height:_____Weight:_____