FitLife CHIROPRACTIC

NEW PATIENT HISTORY

Today's Date: ___________________________________

PATIENT INFORMATION

Name: (Last, First MI)___________________________________ , _________________________________ , __________

Date of Birth:________________________________

Address: ____

City:________________________________ **State:**__________**Zip:**_________________

TELEPHONE:

Home:________________ **Mobile:** __________________ **Work:** __________________ **Other:**_________________

Email: ____

Preferred Language: ____________________________

Smoking Status:

- ○ Every Day
- ○ Some Days
- ○ Former
- ○ Never
- ○ Other

EMERGENCY CONTACT INFORMATION

In case of emergency please contact: ____

Home: _________________________ **Mobile:**_________________________

Relationship to patient:

- ○ Child
- ○ Parent
- ○ Spouse
- ○ Other

Primary care physician:

____

Physician's Phone:__________________________

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FINANCIAL / INSURANCE INFORMATION

Please indicate below what forms of payment will cover cost of your care

- ☐ Insurance
- ☐ Worker's comp
- ☐ Cash
- ☐ Personal injury/auto
- ☐ Other_______________

PRIMARY INSURANCE:

Name of Insured:______________________

Relation to patient:

- ○ Self
- ○ Spouse
- ○ Parent
- ○ Child
- ○ Other

Address:____________________________________

City: _______________**State**_________ **Zip**________

Phone:____________ **Date of birth:**_______________

SECONDARY INSURANCE

Name of Insured:______________________

Relation to patient:

- ○ Self
- ○ Spouse
- ○ Parent
- ○ Child
- ○ Other

Address:____________________________________

City: _______________**State**_________ **Zip**________

Phone:____________ **Date of birth:**_______________

WHO IS RESPONSIBLE FOR PAYMENT?

- ○ Self
- ○ Other – (Relationship) ____________________________

Full Name: ______________________________________ **Phone:** _____________________________

Address:____

City: ________________________________**State**_________ **Zip**______________

I have read the above & below information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with state of Texas statutes.

Patient or Guardian Signature____ **Date**__________________

PLEASE NOTE: ***PAYMENT IS DUE UPON COMPLETION OF SERVICES AS RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE***

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: ____

____

____

____

____

Began When?_____________________ **Describe how complaint began:** ______________________

____

____

What is the intensity/severity of your pain/complaint: from (none) 0 to 10 (severe) _______

Describe the kind/quality of your complaint/pain:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy Dull
- ☐ Stiff
- ☐ Sore
- ☐ Other:______________________________

Describe the frequency of your complaint:

- ○ Constant
- ○ Comes & goes

Worse: ☐ Mornings ☐Mid-day ☐Night

Does this pain radiate to any areas of your body?

- ○ NO
- ○ YES (describe)______________________

____

What has helped your pain?

- ☐ Ice
- ☐ Heat
- ☐ Rest
- ☐ Exercise
- ☐ Stretching
- ☐ Medication
- ☐ Other: ______________________

What makes your pain worse?

- ☐ Sit
- ☐ Stand
- ☐ Walk
- ☐ Run
- ☐ Laying down
- ☐ Sleep
- ☐ Other: ______________________

What daily activities are impeded/stopped due to your condition?____

____

____

For this Current condition have you:

Received any other treatment?

- ☐ None
- ☐ MD
- ☐ PT
- ☐ Massage
- ☐ ER
- ☐ Acupuncture
- ☐ Other: ____________________

Had any previous Surgery or Interventions in this area? (*describe)*____

____

____

Taken any Medications?(*describe)*____

____

Had diagnostic testing?

- ☐ X-ray
- ☐ MRI
- ☐ CT
- ☐ Lab tests
- ☐ Other: ____

Please list all testing dates and results____

____

____

____

Describe any Secondary Complaints: ____

____

____

____

____

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HEALTH HISTORY (*PLEASE US THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEED*

MEDICATIONS:

Allergies to Medications:

- ○ **NONE**
- ○ **List:**

____

____

____

Current Medications:

- ○ **NONE**
- ○ **List:**

____

____

____

PAST MEDICAL HISTORY: (Please list any past)

Surgeries—Date, Type, and Reason:

- ○ **NONE**
- ○ **List:**______________________________

____

____

Major Injuries/Traumas/Hospitalizations:

- ○ **NONE**
- ○ **List:**______________________________

____

____

FAMILY HEALTH HISTORY: (Please mark N/A if not relevant) ☐N/A

List major health problems of immediate relatives:

____

____

____

Deaths in *Immediate* family: *(Cause & what age?)*

____

____

____

SOCIAL & OCCUPATIONAL HISTORY:

Level of Education Completed:

- ○ High School
- ○ Some College
- ○ College Grad.
- ○ Post-Grad.
- ○ Other ______________________

Habits:

- ☐ Cigarettes :#pack/day______________
- ☐ Coffee/Tea Cups/day______________
- ☐ Alcohol Amount/day______________
- ☐ Drugs *(list below+frequency)*

____

____

____

____

Lifestyle: (*Hobbies, Rec. Activities, Exercise, Diet, Work, etc.)*

____

____

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Are you CURRENTLY experiencing any of these symptoms? *(circle all that apply)*

General:
- ☐Recent Weight Change
- ☐Fever
- ☐Fatigue

Musculoskeletal:
- ☐Low back pain
- ☐Mid back pain
- ☐Neck pain
- ☐Arm Problems_____________
- ☐Leg Problems_____________
- ☐Painful Joints
- ☐Stiff/Swollen Joints
- ☐Sore/Weak Muscles/Joints
- ☐Broken Bones
- ☐Other:___________________

Neurological:
- ☐Numbness or tingling
- ☐Loss of feeling
- ☐Dizziness/ light-headed
- ☐Frequent headaches
- ☐Convulsions/Seizures
- ☐Tremors
- ☐Stroke
- ☐Past head injury?
- ☐Past Auto Crash
- ☐Other:___________________

Pulmonary:
- ☐Difficultly Breathing
- ☐Persistent Cough
- ☐Coughing up Blood
- ☐Asthma
- ☐Lung Problems
- ☐Other:___________________

Ear Nose Throat:
- Bleeding gums / mouth sores
- ☐Bad breath or heartburn
- ☐Swollen throat or voice change
- ☐Tinnitus
- ☐Dental Problems
- ☐Swollen Lymph Nodes
- ☐Earache and/or drainage
- ☐Sinus headache
- ☐Allergies
- ☐Nose bleeds
- ☐Hearing loss
- ☐Other:___________________

Urogenital:
- ☐Sexual difficulty
- ☐Kidney stones
- ☐Painful Urination
- ☐Difficult/Straining Urination
- ☐Frequent Urination
- ☐Blood in Urine
- ☐Incontinence/Bed-wetting
- ☐Other:___________________

Skin:
- ☐Dry Skin
- ☐Frequent itching
- ☐Frequent rash
- ☐Recent Skin color change
- ☐Recent change in nails
- ☐Recent change in hair appearance
- ☐Non-healing sores
- ☐Slow-healing sores
- ☐Recent change in mole appearance
- ☐Breast Pain
- ☐Breast Discharge
- ☐Breast Lump

Cardiovascular:
- ☐Chest Pains
- ☐Rapid Heartbeat
- ☐High Blood Pressure
- ☐Swelling--hands, ankles, feet
- ☐Heart problems
- ☐Other:___________________

Psychological:
- ☐Chronic nervousness
- ☐Depression
- ☐Sleep disorder
- ☐Memory loss or confusion
- ☐Other: __________________

Gastrointestinal:
- ☐Loss of Appetite
- ☐Blood in Stool
- ☐Change in Bowel Movements
- ☐Painful Bowel Movements
- ☐Nausea or Vomiting
- ☐Abdominal Pain
- ☐Frequent Diarrhea
- ☐Constipation
- ☐Inflammatory bowel
- ☐Other:___________________

Endocrine System:
- ☐Thyroid Problems
- ☐Diabetes
- ☐Excessive Thirst of Urination
- ☐Glandular or Hormonal
- ☐Conditions
- ☐Change in hat of glove size
- ☐Other:___________________

Blood:
- ☐Anemia
- ☐Easily Bruise or Bleed
- ☐Phlebitis
- ☐Transfusions
- ☐Cold Extremities
- ☐Heat or Cold Intolerance
- ☐Other:___________________

Immune System:
- ☐Swollen Glands
- ☐Leukemia
- ☐Immune Disorder
- ☐Cancer
- ☐Frequent Colds/flu
- ☐Other:___________________

Eyes & Vision:
- ☐Glasses / Contacs use
- ☐Blurred/ double-vision
- ☐Glaucoma / Cataract
- ☐Eye disease or injury
- ☐Other___________________

Female Only:
- ☐Infertility
- ☐Painful periods
- ☐Irregular Periods
- ☐Vaginal Discharge
- ☐Other:

Are you pregnant?
- ☐Yes – Due:_________________
- ☐No – Last Menstruation_________

Pregnancies with Outcome & Date:

____
____
____
____
____
____
____

FitLife CHIROPRACTIC

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. The following is a description of our financial policy:

- Payment for services is due at the time services are rendered
  - We accept cash, checks, & credit card payments
  - We reserve the right to collect before services are rendered

- All charges are your responsibility whether the insurance company pays or not.
  - Not all services are a covered benefit. Benefits may vary as to different insurance plans. We will help with insurance verification and coverage ***but ultimately it is your responsibility to verify your insurance coverage***.
  - If your insurance company does not pay your claim within a reasonable amount of time (approximately 30 days), we will require you to follow up with your insurer and/or pay the balance due.
- Unless you are insured by Medicare or an insurance group which the doctor is a participating provider, or double insured (for procedures being performed), it is our policy to collect 100% of payment at time of rendered service.

- If your are a member of an HMO, PPO, or other Managed Care Program and/or have a Primary Care Physician, ***you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your insurance company.***

- We understand that temporary financial problems may affect timely payment of your balance. We ask that you speak to the doctor if you encounter such problems so that he may assist you in the management of your account.

Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

By signing below you indicate that you have read, understood, and agree to the above financial policies.

PATIENT OR GUARANTOR'S SIGNATURE______________________________ **DATE**_______________________

WITNESS SIGNATURE____ **DATE**_______________________

WELCOME TO FIT LIFE CHIROPRACTIC!

HIPAA NOTICE:

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, health care operation, and coordination of care. We want you to know how your Patient Health Information (hereafter PHI) is going to be used in this office and your rights concerning your records. If you would like a more detailed account of your policy and procedures concerning the privacy of your PHI, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your PHI please inform our office.

Patient's Signature(parent if minor):____ **Date:**____________________

Informed Consent for Chiropractic Treatment:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, and diagnostic x-rays, on me (or on specified minor) by Fit Life Chiropractic/Dr. David Nelson and/or its employees. I understand that I am informed that in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask 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 any future condition(s) for which I seek treatment.

Patient Signature: (parent if minor) ____ Date: ______________________