New Patient Entrance Application

Welcome! We are honored you chose us to evaluate your condition.

If you need assistance please inform the person at the front desk. Thank You!

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Marital Status: Single / Married / Divorced / Other

Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____

Employer Name _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # _____

Guardian/Spouse/Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Children:

Name: _____ Age: _____ Sex: M / F

Name: _____ Age: _____ Sex: M / F

Name: _____ Age: _____ Sex: M / F

Name: _____ Age: _____ Sex: M / F

Referral Information:

How did you find out about us? _____

Patient Informed Consent:

I _____, the undersigned patient, consent to the treatments(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature:_____ Date: _____

Chiropractic Patient History

Location:

What is your primary complaint?_____

What caused the onset?_____

When did it start?_____

Does the complaint radiate or travel? If so, where?_____

Timing and Duration: *(please circle all that apply)*

Since the onset of your complaint how has it been changing? **Getting Better / No Change / Getting Worse**

How often do you experience this complaint? **Constantly / Frequently / Occasionally / Intermittently**

Does your complaint worsen? If so, when? **Morning / Midday / Night / Sleep / Work / Other:**

How much as the complaint interfered with your normal work? *(Including both work outside the home and housework.)*

Not at all / A little bit / Moderately / Quite a bit / Extremely

Severity:

Use the key below to rate the severity of your pain.

0 = No pain 1= Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate

6 = Moderate to Severe 7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciation

Please **circle** where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

How would you describe the sensation of your complaint? *(please circle all that apply)*

Sharp Pain / Shooting / Numbness / Tingling / Tightness / Stiffness

Dull Ache / Burning / Throbbing / Stabbing / Other:_____

Modifying Factors:

What makes your complaint feel worse? *(please circle all that apply)*

Coughing-Sneezing / Standing / Lifting / Exercising / Bending / Twisting / Pushing / Pulling

Sitting / Walking / Driving / Climbing / Other:_____

Alleviating Factors:

What makes your complaint feel better? *(please circle all that apply)*

Rest-Sleep / Stretching / Lifting / Exercising / Bending / Twisting

Pain Medication / Ice / Heat / Shower / Stretching / Walking / Other:_____

Previous Treatment:

Who have you seen for this condition? *(please circle)* Medical Doctor / Physical Therapist / Chiropractor / Other:

Have you had Chiropractic care in the past? If so, when? _____/_____/_____

Risk Factors:

Do you have a pacemaker? Yes No Are you pregnant? Yes No Do you have any metal

implants or devices? Yes No

History was obtained from: Patient / Parent / Guardian / Child / Other:_____

Past and General History

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Whether present and/or past, please mark below with an 'X.'

Medication and Surgical History: Please mark below with an 'X.'

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken	Yes	No	Year
Appendix				***Women***				Anti-Depressants			
Colon				Breast				Birth Control			
Gall Bladder				Uterus				Blood Pressure Medication			
Heart				Ovary				Cholesterol Medication			
Hernia								Cortisone			
Kidney				***Men***				Insulin			
Stomach				Prostate				Male/Female Hormones			
Tonsils								Thyroid Medication			
								Tranquilizers/Sedatives			

What other supplements, vitamins or medications are you taking? _____

_____

_____

What, if any, major injuries have you had, and when? _____

_____

Have you been hospitalized? If so, when and why?_____

_____

Social and Family History

Social History: *(please circle)*

What is the highest level of schooling you have completed?

Still in school / Some high school / High school / Some college / College Graduate

What is your current work status?

Employed [FT] / Employed [PT] / Retired / Unemployed / Disabled / Student

How often do you exercise?

Never / 1-3 times per Month / 1-2 times per Week / 3-4 times per Week /Daily

How would you rate the intensity of your exercise?

Never/ Low Level / Moderate Level / High Level / Competition Level

How many hours do you sleep per night?

<4 hours / 5-6 hours / 7-8 hours / 8-10 hours / >10 hours

How often do you eat a balanced diet?

Never / Rarely / Sometimes/ Regularly / Always

How often do you drink caffeinated beverages?

Never / 1-3 times per Month / 1-2 times per Week / 3-4 times per Week / Daily / >2 Daily

How often do you smoke cigarettes?

Never/ Past / 1-3 Packs per Month / 1-2 Packs per Week / 3-4 Packs per Week / >1 Pack Daily

How often do you drink alcohol?

Never / Past / 1-3 Drinks Monthly / 1-2 Drinks Weekly / 3-4 Drinks Weekly / Daily

Have you used street drugs in the past six months? Yes / No

Daily Activities:

So that we may have an idea as to your daily routine, please list a few of your daily activities and your favorite hobbies.

_____

_____

Does your current condition affect your performance in these activities or hobbies? Yes No If so, how? _____

_____

Family History Information:

Please indicate if anyone in your family currently has, or has in the past, suffered from any of the conditions listed below:

Arthritis Whom: _____ High Blood Pressure Whom: _____ Back Pain Whom: _____ High

Cholesterol Whom: _____ Cancer Whom: _____ Osteoporosis Whom: _____ Diabetes

Whom: _____ Stroke Whom: _____ Heart Disease Whom: _____ Thyroid Conditions

Whom: _____

Patient/Guardian Signature:_____ Date: _____ Dr:_____

What to expect after your first adjustment:

Please read the following information carefully. Sign the bottom of this sheet to indicate that you understand the instructions and information given.

If you have never been adjusted, or if it has been awhile since your last adjustment, you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20 minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting, weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

Unless indicated by the doctor, you may return to work/school after your appointment.

If a sudden movement causes sharp or severe pain or if you experience swelling, contact the clinic at 763.444.4668

I have read and understand the instructions given for my follow-up care.

I understand and agree that Health and Accident insurance policies are in arrangement between an Insurance Carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and any amount to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that all sales of packages, products and items are final, and that there will be no returns or refunds. I also understand that if I suspend or terminate my care and treatment, any fee for professional services to me will be immediately due and payable. I also authorize Nature's Way Chiropractic Clinic to release my health records and reports to my family physician.

Patients Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____