Thrivewell Chiropractic

New Patient Form

Date:_____Name:_____

Age:_____ Birth Date:_____ E-mail: _____ Phone: _____

Address:_____City:_____State:___ Zip:_____

Marital Status: __Married __Single __Widowed/er __Divorced

Occupation:_____

Emergency contact Name and Phone Number _____

Emergency contact relationship to the patient: _____

Do you have a history of stroke or hypertension? ____YES ___NO

Please list any major illnesses, injuries, falls, auto accidents or surgeries?

_____

_____

Have you been treated for any health condition by a physician in the last year?

___Yes ___ No If yes, describe:

_____

Please list any over the counter or prescription medications you are currently taking :

_____

Please list any allergies you have (ie: medications, latex, seasonal etc.)

_____

Please list any Congenital Conditions you have? ___Yes ___No

_____

PAST HISTORY: Please check all that apply

- ❑ Headache/Migraines
- ❑ Arthritis
- ❑ Sciatica
- ❑ Fused/Fixated Joints
- ❑ Herniated Disc
- ❑ Joint Replacement
- ❑ Osteopenia
- ❑ Pacemaker
- ❑ Inflammation
- ❑ Allergies
- ❑ Diabetes
- ❑ Difficulty Urinating
- ❑ Syncope
- ❑ Menstrual Difficulties
- ❑ Cancer
- ❑ Tumors
- ❑ Stroke
- ❑ Seizure Disorders
- ❑ High Blood Pressure
- ❑ Osteoporosis
- ❑ AIDS/HIV
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Hernia
- ❑ Gall Bladder Problems
- ❑ Numbness
- ❑ Weakness

SOCIAL HISTORY- Please check all that you frequently participate in

- ❑ Vigorous Exercise
- ❑ Moderate Exercise
- ❑ Alcohol Use
- ❑ Tobacco Use
- ❑ Caffeine
- ❑ Drug Use

FAMILY HEALTH HISTORY Please check all that apply to your immediate family members

- ❑ Cancer/Tumor
- ❑ Heart Disease
- ❑ Stroke
- ❑ Seizures
- ❑ Diabetes
- ❑ High Blood Pressure

Chief Complaint Questionnaire

What is your primary complaint (purpose of this visit)?

_____

Is it due to an auto accident? __Yes __No Is it due to a work accident? __Yes __ No

Describe the pain/problem, is it:

Sharp ___ Dull___ Ache___ Throb___ Burn___ Tingling___ Weak___ Stiff___
Sore___ Other _____

How frequent is the condition?

- ❑ Constant (>75% of the time)
- ❑ Frequent (75%-50% of the time)
- ❑ Occasional (50%-25% of the time)
- ❑ Intermittent (<25% of the time)

How severe are your symptoms? (0 = no pain, 10 = most pain you've experienced)

1 2 3 4 5 6 7 8 9 10

In recent days, is your problem: The Same ___ Better ___ Getting worse ____

When did it start (please specify a date, or "unknown" if not known)? _____

If this happened before, when was the first time you noticed it ?_____

How did it originally occur?_____

How long does it last? All Day ___ Few Hours ____ Minutes _____

What makes the problem worse?

Stand___ Sit ___ Bend ___ Lift ___ Twist ___ Exercise___ Travel___ Studying___ Stress___
Other _____

What can you do to relieve the problem?

_____

What does this problem prevent you from doing or enjoying?

_____

WOMEN ONLY: Are you pregnant or is there a possibility you may be pregnant?

Yes _____ No_____ Uncertain _____

Are you currently experiencing any of the following?

- ❑ Nausea or vomiting
- ❑ Rapid Eye Movement
- ❑ Difficulty speaking or swallowing
- ❑ Difficulty walking
- ❑ Numbness on one side of the face or body
- ❑ Fainting//lightheadedness
- ❑ Severe Headache
- ❑ Dizziness
- ❑ Double vision
- ❑ Loss of taste/smell

INFORMED CONSENT and HIPAA FORM

PATIENT NAME: _____ DATE: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy	palpation	vital signs
range of motion testing	orthopedic testing	neurological testing
muscle strength testing	postural analysis	radiographic studies

The material risks inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, **if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.**

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.
The availability and nature of other treatment options
Other treatment options for your condition may include:
• Self-administered, over-the-counter analgesics and rest
• Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
• Hospitalization
• Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I understand and agree to allow Thrivewell Chiropractic to use my Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. (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.)

I also agree that Thrivewell Chiropractic, its franchisees, affiliates, vendors, and agents can email me at the email address above in the Patient Information Section, or call or text message me at the number above in the Patient Information Section, even if I am on a federal or state do not call registry for any purpose, including marketing. Message and data rates may apply. I agree that the calls and text messages may be generated using an automatic telephone dialing system and may contain pre-recorded or artificial voice messages. I understand that consenting to receive calls or texts is not required to receive this service.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr McMillon and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Print Name _____

Signature _____ Date: _____

Signature of Parent or Guardian (if a minor) _____ Date: _____