



## New Patient Health History Form

Please fill out all areas accurately

### Patient Data

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date \_\_\_\_\_ Referred by, or heard about Standridge Clinic \_\_\_\_\_

Email \_\_\_\_\_

\*Your email will NOT be shared with any 3<sup>rd</sup> parties, and is used for occasional office announcements and promotions and appointment reminders\*

### Mailing Address

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Cell \_\_\_\_\_ Phone Home \_\_\_\_\_ Phone work \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_ Number of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Describe your daily activities at work \_\_\_\_\_

Employer \_\_\_\_\_ Marital Status \_\_\_M\_\_\_W\_\_\_S\_\_\_D Spouse's Name \_\_\_\_\_

Spouse's Phone # \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Spouse's Work # \_\_\_\_\_

Spouse's Health Status \_\_\_\_\_

### Current Complaints

Area (s) of Injury/Illness/Condition \_\_\_\_\_

Please Describe: (aching, throbbing, numbness, etc) \_\_\_\_\_

Date of onset of symptoms \_\_\_\_\_ If injury, date \_\_\_\_\_ Have you ever had similar condition? \_\_\_\_\_

If yes, When? \_\_\_\_\_ Have you ever been under Chiropractic care? \_\_\_\_\_, If yes, When \_\_\_\_\_

Who did you see? \_\_\_\_\_ Explain treatment received \_\_\_\_\_

Have you been under care with any other practitioners for the condition you are presenting with today? \_\_\_\_\_

If yes, Where? \_\_\_\_\_, Explain treatment received \_\_\_\_\_

### Insurance Information

Name of Party Responsible for Payment \_\_\_\_\_ Phone # \_\_\_\_\_ Do you have health insurance \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

## Signatures

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Chiropractor or Chiropractic group insurance benefits otherwise payable to me. I understand that my Chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of the Insured \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

Have you been treated for any conditions in the last year? \_\_\_ Yes \_\_\_ No

If yes, Please Describe \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Is there a chance that you are pregnant? \_\_\_ Yes \_\_\_ No

Have you had x-rays taken? \_\_\_ Yes \_\_\_ No If Yes, Where? \_\_\_\_\_

What medications are you taking and for what conditions (Please list dosages and amounts, etc)

\_\_\_\_\_

\_\_\_\_\_

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency)

\_\_\_\_\_

\_\_\_\_\_

## Have you ever:

Broken Bones? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Been hospitalized? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Been in an auto accident? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Had Sprains/Strains? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Been struck unconscious? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Had surgery? \_\_\_ Yes \_\_\_ No, Please Briefly Explain \_\_\_\_\_

Under pain management at this time or in the past? \_\_\_ Yes \_\_\_ No, If so, Where? \_\_\_\_\_ When? \_\_\_\_\_

## Family History

Family Members – Present and past health conditions: (Example: heart disease, cancer, diabetes, arthritis, etc.):

\_\_\_\_\_

\_\_\_\_\_

Please explain what activities aggravate your symptoms, be detailed, when, how, etc \_\_\_\_\_

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- Do you experience pain every day?  Yes  No
- Do your symptoms interfere with daily life?  Yes  No
- Does pain wake you up at night?  Yes  No
- Are your symptoms worse during certain times of the day?  Yes  No
- Do changes in weather affect your symptoms?  Yes  No
- Do you wear orthotics?  Yes  No
- Do you take vitamin supplements?  Yes  No

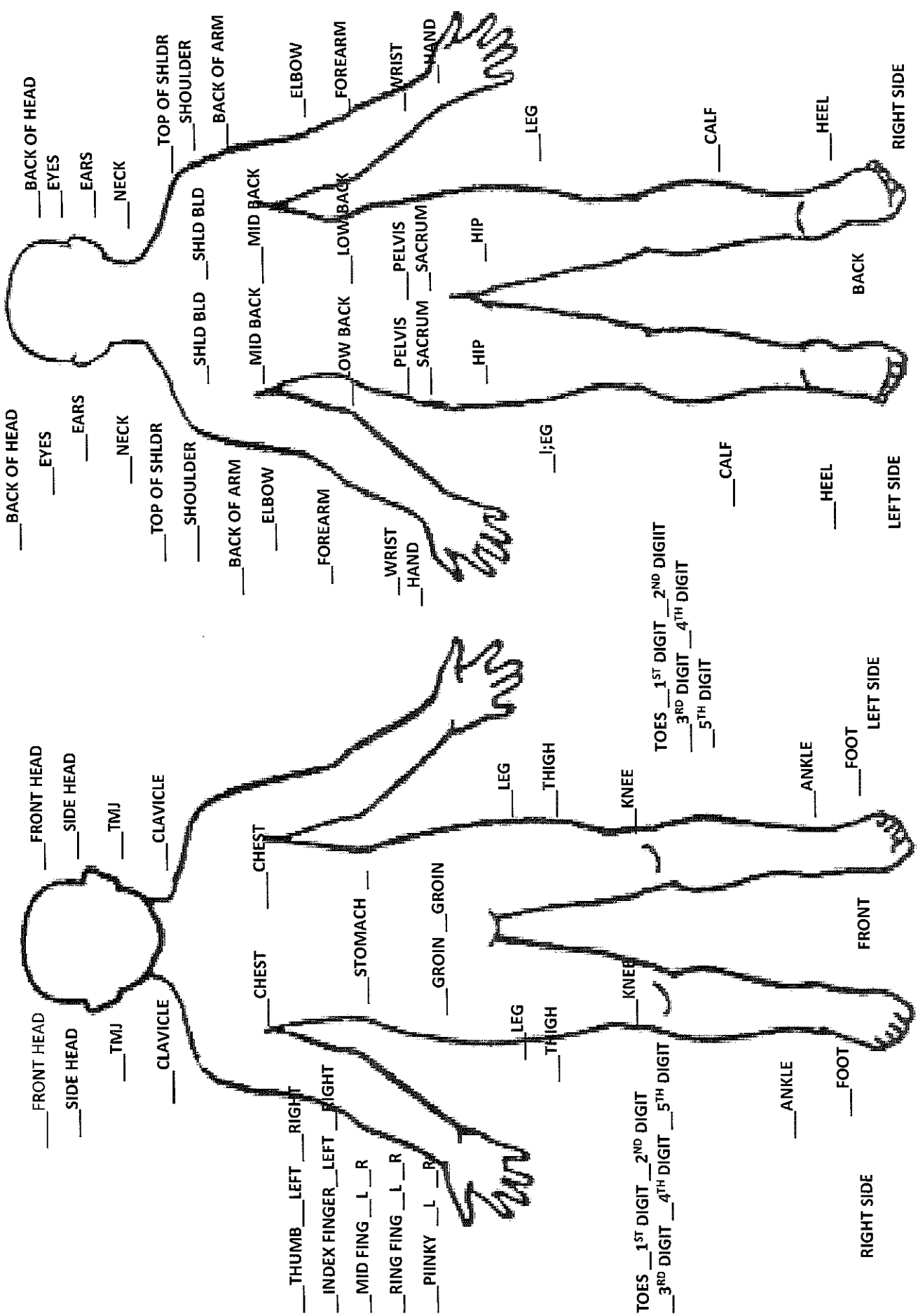
**Habits**

Alcohol	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Coffee	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Tobacco	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Drugs	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Exercise	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Sleep	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Appetite	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Soft Drinks	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Water	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Salty Foods	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Sugary Foods	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy
Artificial Sweeteners	<input type="checkbox"/> None	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy

**Have you ever suffered from:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Ears Ring                | <input type="checkbox"/> Nervousness                |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Excessive Menstruation   | <input type="checkbox"/> Nosebleeds                 |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Eye Pain or Difficulties | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Polio                      |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Frequent Urination       | <input type="checkbox"/> Poor Posture               |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Headache                 | <input type="checkbox"/> Prostate Trouble           |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Hemorrhoids              | <input type="checkbox"/> Sciatica                   |
| <input type="checkbox"/> Breast Lump           | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Shortness of breath        |
| <input type="checkbox"/> Bronchitis            | <input type="checkbox"/> Hot Flashes              | <input type="checkbox"/> Sinus Infection            |
| <input type="checkbox"/> Bruise Easily         | <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Sleep problems or Insomnia |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Irregular Cycle          | <input type="checkbox"/> Spinal Curvatures          |
| <input type="checkbox"/> Chest Pain/Conditions | <input type="checkbox"/> Kidney Infection         | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Cold Extremities      | <input type="checkbox"/> Kidney Stones            | <input type="checkbox"/> Swelling of ankles         |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Loss of memory           | <input type="checkbox"/> Swollen Joints             |
| <input type="checkbox"/> Cramps                | <input type="checkbox"/> Loss of balance          | <input type="checkbox"/> Thyroid Condition          |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Loss of taste            | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Digestion Problems    | <input type="checkbox"/> Lumps in Breast          | <input type="checkbox"/> Varicose Veins             |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Neck Pain or Stiffness   |   |

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ ACCOUNT # \_\_\_\_\_  
 Put a X by the area that you have experienced symptoms in the last 30 days.



Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Account Number \_\_\_\_\_

This must be filled out completely, it is to get an idea of the health issues you are suffering from, the nature of those issues, and how severe the symptoms are. It also helps us to describe for your insurance why you need the services you will be receiving. Please be as thorough and detailed as you can.

Steps for filling out this form – list the worst area first, then continue down with the next, then the next until you have completed your concerns. Use the back page if necessary.

Describe – Example, Area - Neck, Describe - sharp, stabbing, with numbness down left arm to the hand. Activities affected – I can not turn my head to the left to look over my shoulder, Present 100% of the day with a severity level out of 0-10 at 5.

1. Area of concern \_\_\_\_\_

Describe the symptoms \_\_\_\_\_

What activities can you not do as a result of this concern \_\_\_\_\_

What activities are you doing but with pain or symptoms \_\_\_\_\_

Present \_\_\_ 100% \_\_\_ 75% \_\_\_ 50% \_\_\_ 25%

Pain scale (X) \_\_\_ 1(itch) \_\_\_ 2(need bandage) \_\_\_ 3(annoying) \_\_\_ 4(concerning but not limiting)  
\_\_\_ 5(bees?) \_\_\_ 6(bees!!) \_\_\_ 7(crying) \_\_\_ 8(move with pain) \_\_\_ 9(a fire breathing dragon attack) \_\_\_ 10(unconscious)

2. Area of concern \_\_\_\_\_

Describe the symptoms \_\_\_\_\_

What activities can you not do as a result of this concern \_\_\_\_\_

What activities are you doing but with pain or symptoms \_\_\_\_\_

Present \_\_\_ 100% \_\_\_ 75% \_\_\_ 50% \_\_\_ 25%

Pain scale (X) \_\_\_ 1(itch) \_\_\_ 2(need bandage) \_\_\_ 3(annoying) \_\_\_ 4(concerning but not limiting)  
\_\_\_ 5(bees?) \_\_\_ 6(bees!!) \_\_\_ 7(crying) \_\_\_ 8(move with pain) \_\_\_ 9(a fire breathing dragon attack) \_\_\_ 10(unconscious)

3. Area of concern \_\_\_\_\_

Describe the symptoms \_\_\_\_\_

What activities can you not do as a result of this concern \_\_\_\_\_

What activities are you doing but with pain or symptoms \_\_\_\_\_

Present \_\_\_ 100% \_\_\_ 75% \_\_\_ 50% \_\_\_ 25%

Pain scale (X) \_\_\_ 1(itch) \_\_\_ 2(need bandage) \_\_\_ 3(annoying) \_\_\_ 4(concerning but not limiting)  
\_\_\_ 5(bees?) \_\_\_ 6(bees!!) \_\_\_ 7(crying) \_\_\_ 8(move with pain) \_\_\_ 9(a fire breathing dragon attack) \_\_\_ 10(unconscious)

Date \_\_\_\_\_

Our office is now able to send email and text messages to patients to confirm appointments! This is a great tool for our patients to utilize when a phone call isn't possible. However, we understand some patients prefer to simply be called.

Please indicate below if you would like to receive email and text message appointment confirmation and reminders from our office. If so, please provide your cell phone number and/or email address. As always, we will never share your cell phone and email information with any 3<sup>rd</sup> party companies.

- Yes, I would like to receive a text message confirmation.
- No, please do not text me regarding my appointments.

Cell phone number \_\_\_\_\_

- Yes, I would like to receive email appointment confirmations.
- No, please do not email me regarding my appointments.

Email address \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

## INFORMED CONSENT FOR TREATMENT

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_ ACCOUNT# \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions of the doctor before you sign if there is anything that is unclear or of a concern.

### The Nature of the Chiropractic Adjustments

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation 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.

You will receive an analysis, examination, and then a plan of care with treatment recommended for resolution of your health concerns. As a part of the analysis, examination and treatment, you are consenting to the following procedures being performed:

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Spinal manipulative therapy | <input checked="" type="checkbox"/> Palpation          | <input checked="" type="checkbox"/> Vital signs                |
| <input checked="" type="checkbox"/> Range of motion testing     | <input checked="" type="checkbox"/> Orthopedic testing | <input checked="" type="checkbox"/> Basic neurological testing |
| <input checked="" type="checkbox"/> Muscle strength testing     | <input checked="" type="checkbox"/> Postural analysis  | <input checked="" type="checkbox"/> EMS                        |
| <input checked="" type="checkbox"/> Radiographic studies        | <input checked="" type="checkbox"/> Hot/cold therapy   | <input checked="" type="checkbox"/> Mechanical traction        |
| <input checked="" type="checkbox"/> Active therapy and rehab    | <input checked="" type="checkbox"/> Myofascial release |  |

### The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during treatment, this is a list of rare but reported complications following an adjustment. 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 that could cause such injury such as previous stroke or osteoporosis, it is your responsibility to inform me. Of note: In my career I have not had any of these reported in my office following an adjustment I have performed.

### 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 and surgery is an option. If you choose any 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 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 – PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read \_\_\_\_\_ or have had read to me \_\_\_\_\_ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the staff and or doctor and I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided it is my best interest to undergo the treatment recommended.

Having been informed of the risks, I hereby give my consent to the treatment recommended. Date \_\_\_\_\_ Signature of Patient \_\_\_\_\_

## **Consent to use PHI**

### **Acknowledgement for Consent to Use and Disclosure of Protected Health Information**

#### **Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Standridge Clinic and or Structural Rehab or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

#### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. \_\_\_\_\_Patient Initials

#### **Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

#### **Notice of Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

#### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*By my signature below I give my permission to use and disclose my health information.*

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date