Adult New Patient Paperwork

Adult Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:1

First Name: _____ Last Name: _____ DOB: _____ Gender: ○ M ○ F

SSN: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

# of Children: _____ Occupation: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Height: _____ Weight: _____ Email: _____

Cell Phone: _____ Other Phone: _____

2. Emergency Contact: _____ Emergency Relation: _____ Emergency Phone: _____

3. How did you hear about us? (please select all that apply & list who in the box that appears)

☐ Current Patient (list who) _____

☐ Professional Referral/Doctor (list who) _____

☐ Google Search _____

☐ Facebook _____

☐ Community Partner (list who) _____

☐ Other (specify) _____

4. Who is your primary care physician? _____ Date of your last visit: _____

Reason for your last doctor visit: _____

5. Are you also receiving care from any other health professionals?

○ Yes

○ No

6. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

7. Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

8. What health condition(s) bring you into our office?

9. Have you received care for this problem before?

- ○ Yes
- ○ No

If yes, which types of care? Please list

10. When did the conditions first begin?

How did the problem start?
○ Suddenly ○ Gradually ○ Post-Injury

Is this condition:
○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

11. Your top three health goals:

1.

2.

3.

CHIROPRACTIC HISTORY

12. What would you like to gain from chiropractic care?

- ○ Resolve existing challenge
- ○ Overall wellness
- ○ Both

13. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, which practice(s)?

14. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

15. Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

16. Have you ever had any significant falls, surgeries or other injuries as an adult?

- ○ Yes
- ○ No

17. If yes, please explain:

_____

18. Notable childhood injuries?

- ○ Yes
- ○ No

19. If yes, please explain:

_____
_____
_____
_____

20. Youth or college sports?

- ○ Yes
- ○ No

If yes, list major injuries:

_____

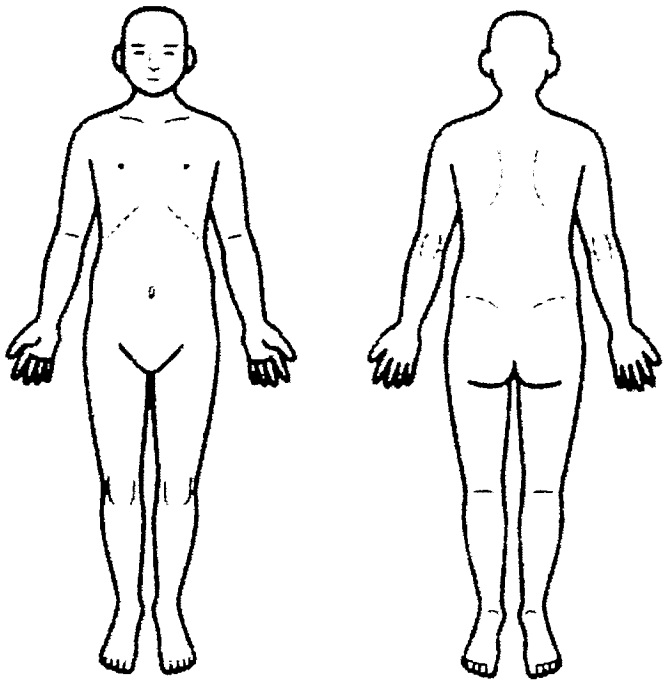
21. Any auto accidents?

- ○ Yes
- ○ No

22. If yes, please explain:

_____
_____
_____
_____

23. *Please indicate where you are experiencing pain or discomfort.*



24. Exercise Frequency?
c None c 1-2x per week c 3-5x per week c Daily

What types of exercise?

_____

25. How do you normally sleep?
c Back c Side c Stomach

Do you wake up:
c Refreshed and ready c Stiff and tired

26. Do you commute to work?

c Yes

c No

If yes, how many minutes per day?

_____

27. List any problems with flexibility (ex. Putting on shoes/socks, etc.):

_____

_____

_____

_____

28. How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

_____

TOXINS: Chemical & Environmental Exposure

29. Please rate your CONSUMPTION for each:

	1 - None	2	3 - Moderate	4	5 - High
Alcohol					
Water					
Sugar					
Dairy					
Gluten					
Processed Foods					
Artificial Sweeteners					
Sugary Drinks					
Cigarettes					
Recreational Drugs					

30. Are you taking any medications?

- ○ Yes
- ○ No

31. If yes, please list which and why:

_____

_____

_____

_____

32. Are you taking any vitamins or supplements?

- ○ Yes
- ○ No

33. If yes, please list which and why:

_____

_____

_____

_____

THOUGHTS: Emotional Stresses & Challenges

34. Please rate your STRESS for each:

	1 - None	2	3 - Moderate	4	5 - High
Home					
Work					
Life					
Money					
Health					
Family					

35. Are there other emotional stresses or challenges you'd like to tell us about?

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

36.

	Past	Present
Anxiety & Constant Stress		
Focus & ADHD Challenges		
Difficulty Sleeping		
Low Energy and Fatigue		
Depression and Mood Regulation Challenges		
Lightheadedness & Dizziness		
Vertigo		
Tension Headaches		
Migraines		
Stiff Neck & Shoulders		
Pain, Numbness, & Tingling in Arms and Hands		
TMJ and Jaw Pain		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		

Strep & Upper Respiratory Infections
Allergies and Autoimmune Challenges
Chronic Inflammation
Acid Reflux, GERD, & Indigestion
Poor Metabolism & Weight Control
High Blood Pressure
Asthma
Chronic Chest Colds & Cough
Bronchitis & Pneumonia
Functional Heart Conditions
Gallbladder Pain & Issues
Stomach Ulcers and Pain
Blood Sugar Problems
Skin Conditions / Rash
Ulcerative Colitis
Crohn's Disease
IBS
Kidney Challenges
Gas Pain & Bloating
Gluten & Casein Intolerance
Constipation
Bladder & Urination Issues
Cysts & Endometriosis
Fertility Challenges
Erectile Dysfunction
Hemorrhoids
Low Back Pain & Stiffness
Sciatica & Radiating Pain
Lumbopelvic / SI Joint Pain
Disc Degeneration
Leg Weakness & Cramps
Restless Legs
Poor Circulation & Cold Feet
Weak Ankles & Arches

ACKNOWLEDGEMENT & CONSENT

37. Patient Name:

_____

_____ _____

Signature Date

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The processing fee for copying your x-rays onto a disc is $15.00, paid in advance. Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. **PLEASE NOTE:** X-rays are utilized in this office to help locate and analyze vertebral subluxations and joint dysfunction.

While these images do add to the safety of your care, these x-rays are not used to investigate for medical pathology. The doctor(s) of Ascension Chiropractic do not diagnose or treat medical conditions; however, we are trained to recognize, abnormalities and signs of contraindication to adjusting and if they are found, we will bring it to your attention, so you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions and any risk involved

_____ ____/____/____

Signature Date

FEMALES ONLY: "I ensure that to the best of my knowledge I am not pregnant."

_____ ____/____/____

Signature Date

DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE - OFFICE USE ONLY

Billing Policies and Fees

- **Consultation** - includes practice member history. This service is complimentary.
- **Assessment (new or established practice member)** - includes one or more of the following: thermography, range of motion, motion and/or static palpation, orthopedic evaluations, leg check. $60-150
- **Chiropractic Adjustment** - The realignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $0-60
- **X-rays** - Specific x-ray views taken of your spine and/or extremities to determine a misalignment/subluxation of your vertebrae and extremity joints. These can also be used to indicate progress after period of care. $50-350

Terms of Acceptance

In order to provide for the most effective healing environment, the most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each practice member with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

- ***Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.***
- ***Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of subluxation(s). Subluxations are deviations from normal spinal and extremity structures and configurations that interfere with normal nerve processes which results in less than optimum body function.***
- ***The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine and extremities with the specific intent of restoring proper motion and nervous system tone. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.***
- ***A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The purpose of this process is to identify any spinal, joint, and nervous system health problems and determine your exact chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.***
- ***Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.***
- ***Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic.***
- ***We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.***

By my signature below, I have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_____ ____/____/____

Signature Date

Medical Information Release Form

Practice Member Name_____Date of Birth_____/_____/_____

Release of Information:

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] My Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages:

Please call [ ] my home [ ] my work [ ] my mobile number_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ]_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____/_____/_____

Signature Date

Informed Consent for Chiropractic Care

When a practice member seeks chiropractic health care, and we accept a practice member for such care, it is essential for both to be working for the same objective. It is important that each understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a practice member, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Other joints in the arms, legs, and jaw are also subject to these same changes. While other healing professions can provide exceptional supplemental and rehabilitative services there is no alternative to the training a chiropractor receives in the specific detection and correction of subluxation. Choosing to not have these corrected may lead to progressive degeneration and dysfunction, worsening symptoms, increased pain, and increased need for medical interventions.

Subluxations are corrected by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by highly-specific manual adjustments of the spine and extremities. Adjustments are done by hand in this office.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

As with anything in life, there is always some risk involved. Due to the nature of physics and the transfer of a force and the dynamic nature of the human body, there is a low risk of trauma-like injury such bruising, soreness, sprain/strain, fracture, dislocation. Sometimes, in the healing process, symptoms can worsen before they begin to improve. Ascension Chiropractic team members are trained to recognize underlying conditions that may contribute to these events. Dr. Ryan Yocum has received specific technique training to greatly decrease the risk of these events occurring. Your health and well-being are our greatest priority.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore consent to chiropractic care on this basis.

_____

Print Name

_____ ____/____/____

Signature Date