New Patient History (Please Print)

Date:_____

Name: _____ **Email:** _____

Phone: (Home) _____ **(Mobile)** _____ **(Work)** _____

Address: _____ **City:** _____ **Zip:** _____

Birth Date: ____/____/_____ □ **Male** □ **Female** **Spouse/Parent Name:** _____

# of Children: _____ □ **Married** □ **Single** ❑ **Minor** □ **Divorced** □ **Widowed**

Are you Pregnant? □ **YES** □ **NO** **Due Date:**_____

Occupation: _____ **Employer:** _____

Emergency contact:_____**Relation:**_____

Phone #: (H)_____**(W)**_____**(C)** _____

How were you referred to our office? _____

Have you ever had Chiropractic Care before? _____ **If yes, when?** _____

List your chief complaints in order of severity; Check all those that describe your condition:

Complaint 1: _____ **For How Long?** _____

What originally caused this problem? _____

Feels Like:

□ **Sharp** □ **Throbbing** □ **Shooting** □ **Cramps** □ **Stiffness** □ **Dull Ache** □ **Numb/Tingling**
□ **Burning** □ **Other:** _____

Bothers Me:

□ **Constant (100%)** □ **Frequent (50%-75%)** □ **Occasional (25%-50%)** □ **Intermittent (1%-25%)**

It Has Been:

□ **Getting Worse** □ **Staying Same** □ **Getting Better**

Pain Scale: (0=No Pain – 10=Severe Pain)

□ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10**

During The Day It Is:

□ **Worse in the AM** □ **Stays the same throughout the day** □ **Worse in the PM**

The Following Increases Pain:

□ **Moving** □ **Sitting** □ **Lifting** □ **Bending** □ **Walking** □ **Laying Down** □ **Other:** _____

The Following Decreases Pain:

□ **Moving** □ **Sitting** □ **Lifting** □ **Bending** □ **Walking** □ **Laying Down** □ **Other:** _____

Does The Pain Travel/Radiate? :

□ **Yes** □ **No** **If yes, where**_____ **to** _____

Complaint 2: _____ **For How Long?** _____

What originally caused this problem? _____

Feels Like:

□ **Sharp** □ **Throbbing** □ **Shooting** □ **Cramps** □ **Stiffness** □ **Dull Ache** □ **Numb/Tingling**
□ **Burning** □ **Other:** _____

Bothers Me:

□ **Constant (100%)** □ **Frequent (50%-75%)** □ **Intermittent (25%-50%)** □ **Occasional (1%-25%)**

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Pain Scale: (0=No Pain – 10=Severe Pain)

□ **1** □ **2** □ **3** □ **4** □ **5** □ **6** □ **7** □ **8** □ **9** □ **10**

During The Day It Is:

□ **Worse in the AM** □ **Stays the same throughout the day** □ **Worse in the PM**

The Following Increases Pain:

□ **Moving** □ **Sitting** □ **Lifting** □ **Bending** □ **Walking** □ **Laying Down** □ **Other:** _____

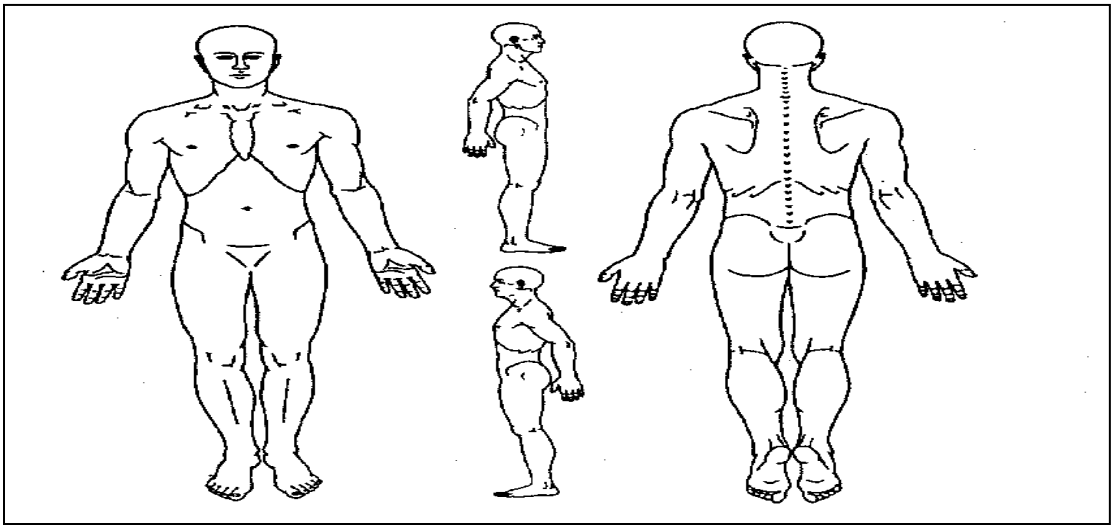
The Following Decreases Pain:

□ **Moving** □ **Sitting** □ **Lifting** □ **Bending** □ **Walking** □ **Laying Down** □ **Other:** _____

Does The Pain Travel/Radiate? :

□ **Yes** □ **No** **If yes, where**_____ **to** _____

Mark an "X" on the areas you feel pain. Draw an arrow if the pain travels. Include all affected



Does your condition interfere with your:

Work	□ **NO**	□ **MILD**	□ **MODERATE**	□ **SEVERE**
Sleep	□ **NO**	□ **MILD**	□ **MODERATE**	□ **SEVERE**
Daily Routine	□ **NO**	□ **MILD**	□ **MODERATE**	□ **SEVERE**
Recreation	□ **NO**	□ **MILD**	□ **MODERATE**	□ **SEVERE**

Does your condition interfere with any of the following:

□ **Computer Use**	□ **Cleaning**	□ **Shopping**
□ **Sports**	□ **Cooking**	□ **Gardening**
□ **Reading**	□ **Watching Kids**	□ **School**
□ **Exercise**	□ **Yard Work**	□ **Self Care**
□ **Vacuuming**	□ **Driving**	□ **Other: _____**
□ **Social Life**	□ **Relationship**	

List of Previous Hospital Stays/Surgeries: (What and When?)

_____

_____

_____

List of Any Childhood Traumas / Accidents / Falls / Auto Injuries: (What happened and When?)

_____

_____

_____

Current Medications/Supplements

Medication/Dose/How often	Reason for taking	Prescribing M.D.

Health History (Check if you have now or have had in the past:)

□ **Abdominal Aortic Aneurysm**	□ **Erectile Dysfunction**	□ **Mumps**
□ **AIDS/HIV**	□ **Eye Troubles**	□ **Osteoporosis**
□ **Alcoholism**	□ **Fractures**	□ **Pacemaker**
□ **Allergy Shots**	□ **Glaucoma**	□ **Parkinson's**
□ **Anemia**	□ **Goiter**	□ **Pneumonia**
□ **Anorexia**	□ **Gonorrhea**	□ **Prostate Problems**
□ **Appendicitis**	□ **Gout**	□ **Psychiatric Care**
□ **Bleeding Disorders**	□ **Heart Disease**	□ **Rheumatoid Arthritis**
□ **Bulimia**	□ **Heart Issues**	□ **Stroke**
□ **Buzzing/Ringing in Ears**	□ **Hepatitis**	□ **Suicide Attempt**
□ **Cancer**	□ **Hernia**	□ **Swollen Ankles**
□ **Cataracts**	□ **Herniated Disc**	□ **Throat Conditions**
□ **Chemical Dependency**	□ **Herpes**	□ **Thyroid Conditions**
□ **Chicken Pox**	□ **High Cholesterol**	□ **Tuberculosis**
□ **Chronic Bronchitis**	□ **Hypertension/ HBP**	□ **Tumors/Growths**
□ **Chronic Fatigue**	□ **Indigestion**	□ **Typhoid Fever**
□ **Chronic Tonsillitis**	□ **Kidney Disease**	□ **Ulcers**
□ **Constipation**	□ **Kidney Stones**	□ **Unexplained Memory Loss**
□ **Coronary Artery Disease**	□ **Liver Disease**	□ **Unexplained Weight Loss**
□ **Diabetes**	□ **Measles**	□ **Unexplained Weight Gain**
□ **Diarrhea**	□ **Menstrual Problems**	□ **UTI**
□ **Digestive Problems**	□ **Mid Back Pain**	□ **Vaginal Infections**
□ **Dysmenorrhea**	□ **Miscarriage**	□ **Venereal Disease**
□ **Eczema**	□ **Mononucleosis**	□ **Whooping Cough**
□ **Emphysema**	□ **Multiple Sclerosis**	□ **Other:**_____

Family History: Please specify members of your family including extended family who have these illnesses.

Cancer:_____ Hypothyroidism:_____
Heart Disease:_____ High Blood Pressure: _____
Hypoglycemia:_____ Obesity: _____
Back Problems: _____ Scoliosis:_____

Concerns:

We've found that these are the common concerns people like you have. We want to make sure you are comfortable before we start care. Please circle all that apply, **star your top 3** and add any others that are important to you.	
Is it going to hurt?	I don't want to be cracked
Do I have to come forever?	Is it addictive?
Are the X-rays dangerous?	Is it safe for children?
Is it expensive?	What if insurance does not cover chiropractic?
What do I do if chiropractic does not work?	Can this be fixed?

Strengths:

Strong habits are key to health. It helps us understand how you will heal when we know your health habits. Please circle all that apply, **star your top 3** and add any others that you may have.	
Stretch 3-5 times a week	Exercise 3-5 times a week
Drink ½ my body weight of ounces of water	Take supplements for health
Have a positive attitude	Sleep 6-8 hours a night
Drink or eat something green everyday	Get maintenance chiropractic 2-4 times a year
Do activities to minimize stress regularly	Non-smoker

Goals:

We want to make sure you get lasting relief and help you in every way possible. Please circle any functional goals that you have, **star your top 3** and add any others that are important to you.	
Sleep through the night	Exercise again
Continue working/get back to work	Avoid future flare ups
Play with kids/grandkids normally	Get off pain medications
Be ready for an upcoming event	Have a better attitude
Have some moments of relief	Sit/stand comfortably for an extended period

Is there anything else you think we should know about or that you would like to discuss? (Explain):

_____

_____

_____

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third party payer for purposes of reimbursement for services provided, and only upon direct request of your third party payer.

Patient Signature_____ **Date**_____

Authorization and Assignment

Please initial next to each line that applies to you. Thank you.

__**AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

__**ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

__**MEDICARE ASSIGNMENT (*if applicable*):** I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

__**ACKNOWLEDGEMMENT AND UNDERSTANDING:** I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or
B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Northwest Health Center LTD (DBA: Momentum Health Center), will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

Patient Signature_____ **Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, AND/OR CHIROPRACTIC CARE.

I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Northwest Health Center LTD (DBA: Momentum Health Center). I understand and am informed that, while extremely rare, there are some risks to treatment, including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient Signature_____ **Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____