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)** _____

Would you prefer email _____ **or text message**_____**(write SMS carrier) reminders for upcoming appointments?**

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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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:** _____

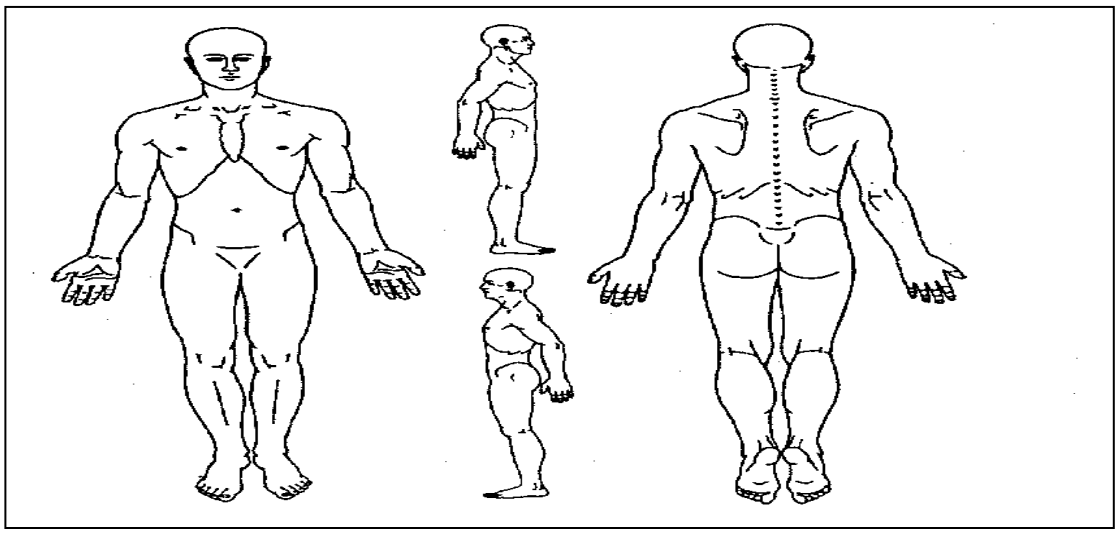
The Following Decreases Pain:

□ **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**	

Pregnancy Questionnaire

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? Y N
How many pregnancies have you had? _____ Miscarriages? _____ Abortions? _____

Previous Birth History
Name of Child: _____ Date of Birth: _____
Location of Birth (circle): Hospital Birth Center Home
Were you induced? Y N
Did you receive an Epidural? Y N
How long was the entire labor? _____
Did you deliver vaginally? Y N
If yes, how long did you push? _____
Was there any pulling on the baby's head? Y N
Forceps or vacuum extractions? Y N
Position during delivery (circle): Lying on back w/feet up Kneeling Squatting Other
Presentation of baby at time of delivery (circle): Normal Posterior Breech Facial Brow

CONCEPTION & EARLY PREGNANCY

How many weeks pregnant are you? _____
When is your expected or calculate due date? _____
Date of missed period _____
Did you have difficulty conceiving? Y N
If yes, please explain: _____
_____
Have you ever used any form of hormonal or oral contraceptives? Y N
Which ones? _____
How long? _____
What was your pre-pregnancy weight? _____lbs Current weight? _____lbs

CURRENT HEALTH CONDITIONS

Why type of exercises are you currently performing? _____
_____
Please list any prescription medications taken during this pregnancy: _____
_____
Please list any vitamins or supplements take during this pregnancy: _____
_____
Have you had any slips, falls or other physical traumas during this pregnancy? (Circle) Y N
If yes, please explain: _____
Are you currently or have you experienced any of the following during this pregnancy? (Circle)

Spotting or bleeding	Midback or Rib pain	Pre-eclampsia/eclampsia
Vomiting	Hemorrhoids	Sciatica
Bladder Infection	High blood pressure	Numb hands
Headaches	Groin pain	Heart burn
Hip pain	Low back pain	Morning sickness
Diabetes	Premature contractions	Neck paln

YOUR BIRTH PLAN

Please list the top three goals for this pregnancy:

1.
2.
3.

Please list the most significant fears associated with this pregnancy

1.
2.
3.

Do you currently have a birth plan? Y N

If yes, please explain: _____

_____

Do you wish to have a natural vaginal labor and delivery? Y N

If not, what concerns do you have? _____

Are you OK with the use of the following (circle): Epidural Pitocin Vaccinations Ultrasounds

Are you taking any pre-natal or birthing classes? Y N

If yes, please explain: _____

_____

Who is your OB/GYN or midwife? _____

Do you intend to have a doula or birth coach present? Y N

Rate your stress scale 1-10 _____

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**_____

Momentum Health Center COVID-19 Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that Momentum Health Center has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Momentum Health Center cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others.

I voluntarily seek services provided by Momentum Health Center and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:
* I am not experiencing any symptoms of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Momentum Health Center harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the health center, or that may otherwise arise in any way in connection with any services received from Momentum Health Center. I understand that this release discharges Momentum Health Center from any liability or claim that I, my heirs, or any personal representatives may have against the office/clinic with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Momentum Health Center. This liability waiver and release extends to the health center together with all owners, partners, and employees.

Name Printed: _____ Signature: _____

Date:_____