

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 _____ reminders for upcoming appointments?

Circle your cell phone carrier: Verizon AT&T T-Mobile Sprint Other: _____

How were you referred to our office? _____

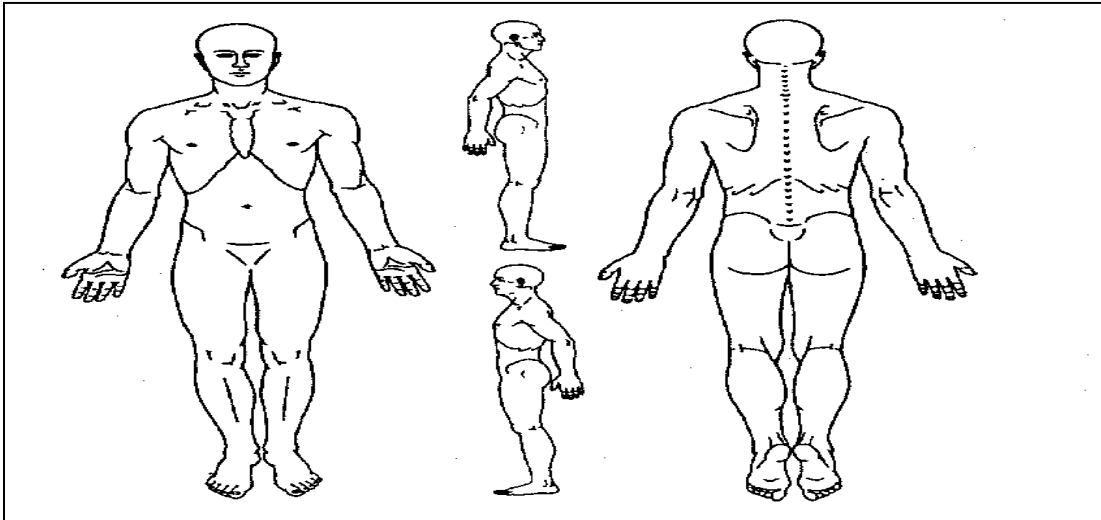
Have you ever had Chiropractic Care before? _____ If yes, when? _____

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:	
<input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Dull Ache <input type="checkbox"/> Numb/Tingling	
<input type="checkbox"/> Burning <input type="checkbox"/> Other: _____	
Bothers Me:	
<input type="checkbox"/> Constant (100%) <input type="checkbox"/> Frequent (50%-75%) <input type="checkbox"/> Occasional (25%-50%) <input type="checkbox"/> Intermittent (1%-25%)	
It Has Been:	
<input type="checkbox"/> Getting Worse <input type="checkbox"/> Staying Same <input type="checkbox"/> Getting Better	
Pain Scale: (0=No Pain – 10=Severe Pain)	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
During The Day It Is:	
<input type="checkbox"/> Worse in the AM <input type="checkbox"/> Stays the same throughout the day <input type="checkbox"/> Worse in the PM	
The Following Increases Pain:	
<input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____	
The Following Decreases Pain:	
<input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____	
Does The Pain Travel/Radiate? :	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where _____ to _____	

Complaint 2: _____	For How Long? _____
What originally caused this problem? _____	
Feels Like:	
<input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Shooting <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Dull Ache <input type="checkbox"/> Numb/Tingling	
<input type="checkbox"/> Burning <input type="checkbox"/> Other: _____	
Bothers Me:	
<input type="checkbox"/> Constant (100%) <input type="checkbox"/> Frequent (50%-75%) <input type="checkbox"/> Occasional(25%-50%) <input type="checkbox"/> Intermittent (1%-25%)	
It Has Been:	
<input type="checkbox"/> Getting Worse <input type="checkbox"/> Staying Same <input type="checkbox"/> Getting Better	
Pain Scale: (0=No Pain – 10=Severe Pain)	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
During The Day It Is:	
<input type="checkbox"/> Worse in the AM <input type="checkbox"/> Stays the same throughout the day <input type="checkbox"/> Worse in the PM	
The Following Increases Pain:	
<input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____	
The Following Decreases Pain:	
<input type="checkbox"/> Moving <input type="checkbox"/> Sitting <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Laying Down <input type="checkbox"/> Other: _____	
Does The Pain Travel/Radiate? :	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Sleep	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Daily Routine	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Recreation	<input type="checkbox"/> NO	<input type="checkbox"/> MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE

Does your condition interfere with any of the following:

- | | | |
|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Computer Use | <input type="checkbox"/> Cleaning | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Cooking | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Watching Kids | <input type="checkbox"/> School |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Yard Work | <input type="checkbox"/> Self Care |
| <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Driving | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Social Life | <input type="checkbox"/> 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

[illegible]

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

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

___ **ACKNOWLEDGEMENT 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: _____