ProCare Chiropractic & Sports Therapy

Please Print Clearly

New Patient Information

Today's Date: _____

Full Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Gender M / F E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status S / M / D / W Work Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

How did you hear about ProCare Chiropractic? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The Patient understands and agrees to allow ProCare Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office will not release any of your records without your written permission.

3. A patient's written consent need only be obtained one time for all the subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and rights to privacy, all staff has been trained in the area to patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by ProCare Chiropractic to assure that your records are not readily available to those who do not need them.

6. If a patient has a complaint about the privacy of records please see our office manager or Dr. Gingell.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature Date

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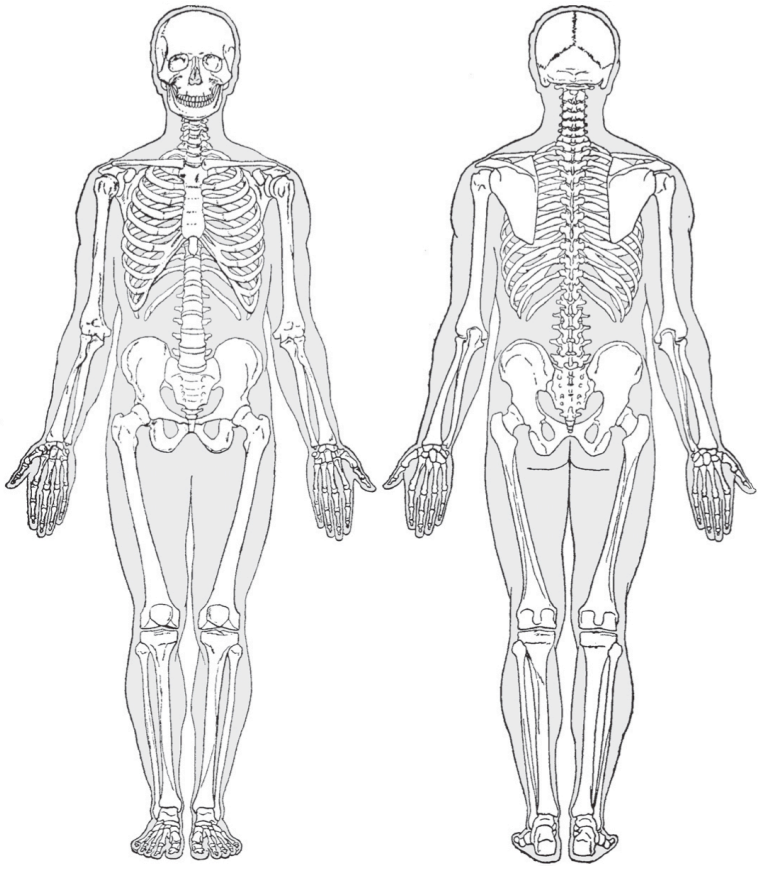
Please list and describe the problem(s) you are having and draw them on the chart below.

1. _____

2. _____



GRADE YOUR PAIN

1 (none) to 10 (very severe)

PROBLEM #	GRADE
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10

A = Ache
B = Burning
S = Stiffness
N = Numbness
T = Tingling
O = Pain

When did your symptoms start? _____ Is this a recurring problem? ☐ Y ☐ N

How did the problem(s) originally occur? _____

Has another doctor(s) treated you for this condition ☐ Y ☐ N If yes, whom? _____

How frequent is this condition? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally ☐ At Night Only

How long does it last? ☐ All Day ☐ A Few Hours ☐ Comes and Goes

Has it become worse recently? ☐ Y ☐ N ☐ Same ☐ Better ☐ Gradually Worse ☐ Rapidly Worse

What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Other: _____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other: _____

Is there anything you do to relieve the problem(s)? If yes, please describe what you do and your results. _____

_____

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Please check all of the symptoms that apply: (P = Past / C = Current)

P / C	Systemic Conditions	P / C	Cardiovascular	P / C	Neurological	P / C	Metabolic
☐ ☐	Cancer	☐ ☐	Chest Pain	☐ ☐	Concussion	☐ ☐	Weight Loss/Gain
☐ ☐	Chronic Fatigue	☐ ☐	Fainting	☐ ☐	Memory Loss	☐ ☐	Low Bone Density
☐ ☐	Systemic Lupus	☐ ☐	High Blood Pressure	☐ ☐	Epilepsy	☐ ☐	Excessive Thirst
☐ ☐	Immune Disease	☐ ☐	Stroke	☐ ☐	Excessive Weakness	☐ ☐	Hormone Therapy
☐ ☐	Hepatitis	☐ ☐	Heart Attack	☐ ☐	Loss of Sensation	☐ ☐	Thyroid Problems
☐ ☐	Anemia	☐ ☐	Blood Clots	☐ ☐	Dizziness		**Psychological**
☐ ☐	Arthritis	☐ ☐	Vascular Disease		**Gastrointestinal**	☐ ☐	Depression
☐ ☐	Swelling/Stiffness			☐ ☐	Abdominal Pain	☐ ☐	Anxiety
				☐ ☐	Liver/Gallbladder	☐ ☐	Alcohol/Drug Abuse
				☐ ☐	Ulcer	☐ ☐	Mood Swings
						☐ ☐	Insomnia

MEDICATIONS: List all medications (Rx & OTC) that you are currently taking because of the associated condition.

_____

HOSPITALIZATIONS/SURGERIES: _____

FAMILY HISTORY: List any major diseases (bone/joint diseases, cancer, diabetes, heart problems, etc.) in your family.

_____

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking/Moving ☐ Driving

SPORTS/ATHLETIC HISTORY:

What physical activities do you participate in currently (marathon, crossfit, bootcamp, etc.)?

_____

How often do you train? _____

Do you currently, or in the recent past, train with a coach? ☐ Y ☐ N

What are your end goals?

☐ General Health ☐ Weight Loss ☐ Increase Muscle Mass ☐ Specific Race Distance: _____

☐ Sport-Specific Training: _____ ☐ Other: _____

Are you taking any supplements/vitamins or are you on a specialized diet? ☐ Y ☐ N If yes, what? _____

_____

Disclosure & Consent To Chiropractic Treatment

Doctors of chiropractic who utilize spinal manipulation and other manual therapy techniques are required to advise patients about the potential risks associated with such procedures. We are also required to inform you of other treatment options, should you inquire about them.

A. While rare, some patients may experience short-term aggravation of symptoms, fractures, or muscle and ligament strains/sprains as a result of spinal manipulation.

B. There have been reported cases of stroke associated with manipulation of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasions result in injuries including paralysis. The possibility of such injuries resulting from upper cervical adjustments is extremely rare.

C. There are rare reported cases of disc injuries following spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to you overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical procedures, medications, and treatments give for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature of my condition and the various treatment modalities to be used in my treatment. I also acknowledge that I have been informed of the possible side effects of such treatment, as well as other possible treatment options.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor. I intend this consent to apply to my present and all my future visits.

Dated this _____ day of _____, 2017.

_____ _____
Patient Signature (or legal guardian) Doctor's Signature

_____ _____
Print Patient's Name Print Doctor's Name