New Patient Health History Form

Patient Data

First Name_____Last Name_____Email_____

*Your email will NOT be shared with any 3rd parties, and is used only for occasional office announcements and promotions.

Mailing Address

Address_____City_____State___Zip_____Birth Date_____

Age_____Male__Female__Cell Phone( )_____Cell Carrier _____(Txt Appt. Reminders)

SS#_____Occupation_____Employer_____

Number of children_____Marital status_____Spouse's Name_____Referred By_____

Emergency Contact_____Phone_____

Current Complaints

Nature of Injury ____Auto____Work____Other Please describe your symptoms_____

_____

Is it possible that your injury was caused by an auto accident within the last 2 years?__YES__NO
Have you retained an attorney?__YES__NO

Date of Injury_____Date symptoms appeared_____Have you had the condition before?___YES___NO

If yes, when?_____Have you ever been under chiropractic care?_____

List other practitioners seen for this injury/condition_____

Insurance Information

Name of party responsible for payment_____phone_____

Do you have health insurance?____YES____NO Name of company_____

Subscriber's Name_____DOB_____Policy ID#_____Employer_____

Do you have a secondary health insurance?____YES____NO If yes, Insurance Company Name_____

Subscriber Name_____DOB_____Policy ID#_____Employer_____

Signatures

(_____)*understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.*

Patient's Signature_____Date_____

Spouse's or Guardian's Signature_____Date_____

Medical History

Have you been treated for any conditions in the last year? ____ YES ____ NO

If yes, please describe:

_____

_____

Date of last physical exam _____ Date of last blood work _____

Is there a chance you are pregnant? ____ YES ____ NO

Have you had x-rays taken? ___ YES ___ NO If yes, where? _____

Please **list all medications** you are taking and for what conditions:

_____

_____

What vitamins, minerals, or herbs do you currently take? _____

Have you ever:

Been in an auto accident? __ YES __ NO Explain: _____

Broken bones? __ YES __ NO Explain: _____

Been hospitalized? __ YES __ NO Explain: _____

Had any surgeries? __ YES __ NO Explain: _____

Had any sprains/strains? __ YES __ NO Explain: _____

Had any head injuries? __ YES __ NO Explain: _____

Family History

Please list any past or present health conditions of your parents (example: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

Allergens

Please list any allergies and your reaction upon exposure:

_____

_____

Have you ever suffered from:

___ Anemia
___ Arteriosclerosis
___ Arthritis
___ Bronchitis
___ Cancer
___ Chest pain/conditions
___ Constipation
___ Depression
___ Diabetes
___ Digestion problems
___ Dizziness
___ Ears ringing
___ Excessive menstruation
___ Eye pain difficulties
___ Fatigue
___ Frequent urination
___ Headache
___ High blood pressure
___ Irregular heart beat
___ Irregular menstrual cycle
___ Kidney infection
___ Kidney stones
___ Loss of memory
___ Loss of balance
___ Loss of smell
___ Loss of taste
___ Muscle cramps
___ Neck pain
___ Neck stiffness
___ Nervousness/Anxiety
___ Pacemaker
___ Poor posture
___ Prostate trouble
___ Sciatica
___ Shortness of breath
___ Spinal curvatures
___ STD
___ Stroke
___ Swelling of ankles
___ Swollen joints
___ Thyroid condition
___ Ulcers

Habits

Check what best applies to you and answer the following questions:

Alcohol ____ None ____ Casual ____ Moderate ____ Heavy

Caffeine ____ None ____ Less than 3 drinks per day ____ 3-6 per day ____ More than 6 per day

Smoking ____ Never ____ Currently every day ____ Currently some days ____ Former

Drug Use ____ None ____ Recreational ____ Addiction

Exercise ____ None ____ Rarely ____ 2-4 times per week ____ Daily

How many ounces/cups of water do you drink per day?

_____

How would you describe your appetite?

_____

What are your sleeping habits?

_____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of Chiropractic, medical doctors, osteopathic physicians and physical therapists who use manual therapy techniques such as manipulation of the spine and or extremities are required to advise patients that, although extremely rare, there may be some risks associated with such treatment.

In particular on rare occasions, patients have experienced rib fractures, muscular strains, or ligamentous sprains following spinal adjustments. Some types of spinal adjustments of the neck leading to or contributing to complications including stroke. This has been the subject of tremendous disagreement within and out of the profession, with one prominent authority stating that at most there is a one in one million chance of a stroke occurring as a result of a chiropractic adjustment of the neck. We employ tests in our examination which are designed to identify such susceptibility to that kind of injury. There have also been rare reported cases of disc injuries in the time following manipulation of the spine, although no scientific study has ever demonstrated with certainty that disc injuries have been specifically resulted by such treatment.

Chiropractic treatment including manipulation has been the subject of governmental reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches, nerve pain, and many other conditions. Chiropractic care contributes to your overall well being. The risks of injury or complications from chiropractic treatment are substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same conditions.

PLEASE READ BEFORE SIGNING

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatment which the doctor feels at the time based on the facts then known, is in my best interests. I understand that the results are not guaranteed. I acknowledge that I have discussed or have had the opportunity to discuss with my chiropractor the nature and purpose of the chiropractic treatment which I am about to receive (including chiropractic manipulation) as well as the contents of this consent form. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including chiropractic manipulation.

Print Name_____ Date_____

Signature (Patient/Guardian)_____

Witness_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specified adjustments of the spine.
Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interferes with the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. If during the course of a chiropractic spinal examination, however, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. We may use other procedures, however, to help your body hold the adjustments.

I, _____, have read and fully understand the above statements.
I therefore accept chiropractic care on this basis.
Patient Signature: _____ Date: _____

Pregnancy Release

This is to certify that to the best of my knowledge, I, _____, am not pregnant and Pure Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Patient Signature: _____ Date: _____

Consent to Evaluate and Adjust a Minor

I, _____ (Print name), being the parent or legal guardian of _____ (Print child's name), have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian Signature: _____ Date: _____

ASSIGNMENT OF PROCEEDS

(Agreement)

I understand that I remain personally responsible for the total amounts due to **Pure Chiropractic** for their services. This Agreement does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **Pure Chiropractic** for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of **Pure Chiropractic** and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

Patient Name (please print): _____

Patient Signature: _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian (please print): _____

Parent/Guardian's Signature: _____ Date: ___/___/___

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NOTICE OF PRIVACY PRACTICES (HIPPA)

I, _____ acknowledge being informed of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I am fully aware and fully understand that there is a copy located in the patient waiting room for my convenience. I fully understand that HIPPA is a notice describing:

* Pure Chiropractic's commitment to my privacy
* How Pure Chiropractic may use and disclose my identifiable health information
* My rights regarding my individually identifiable health information

I furthermore understand that the terms of the HIPPA notice apply to all records containing my individually identifiable health information that is created or retained by Anthony Becerra, D.C. at Pure Chiropractic. Pure Chiropractic reserves the right to revise or amend the Notice of Privacy Practices (HIPPA). Any revision or amendments to the HIPPA notice will be effective for all my records that Anthony Becerra, D.C. or Pure Chiropractic may create or maintain in the future. Pure Chiropractic will post a copy of their most current HIPPA notice in a visible location in the patient waiting room at all times. I am also fully aware that I may request a copy of Pure Chiropractic's most current HIPPA notice at any time.

_____	_____	_____
Print Patient's Full Name	Patient Signature	Date

pure chiropractic
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APPOINTMENT CANCELLATION & NO SHOW POLICY

APPOINTMENTS

At Pure Chiropractic there is nothing more important than our commitment to your health. We take this responsibility very seriously. Please arrive on time for your appointments. Our doctors do their best to stay on schedule and we all respect your time. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and, when it is missed, that time cannot be used to treat another patient.

CANCELLATION / NO SHOW POLICY

If you need to cancel or reschedule your appointment we kindly ask that you give us a 24-hour notice. This policy allows other patients access to care when needed and to avoid the expense to our office due to late cancellations and no shows. We take your time very seriously and are committed to providing you with the highest level of care.

If you call with less than 24-hour notice or if you do not call at all, we reserve the right to bill you for the time we reserved especially for you. The Cancellation / No Show Fee is $25 for chiropractic treatment visits and $50 for chiropractic review of findings and new patient visits. We understand there are unpredictable situations that cannot be helped so please contact us to share your unique situation.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation / No Show Policy of Pure Chiropractic and I agree to be bound by its terms.

Patient's Signature Date