

Date \_\_\_\_\_

New Patient

Returning Patient

**PATIENT INFORMATION**

Returning patients check here if all of the following information is the same

Patient Name \_\_\_\_\_  
\_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Email \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Contact Number \_\_\_\_\_

**Who may we thank for referring you?**

\_\_\_\_\_

**HOW CAN WE HELP YOU?**

Describe your current problems and how it began \_\_\_\_\_

Work related.  Auto related  Other (explain) \_\_\_\_\_

Approximate date problem began \_\_\_\_\_ How problem began \_\_\_\_\_

How bad is it? How intense are your symptoms? (circle) **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**  
NO SYMPTOMS INTENSE SYMPTOMS

How often are the symptoms present? \_\_\_\_\_

In the past week, how much has your problem interfered with your daily activities (eg. Work, social activities or household chores)?

Circle below

**0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**  
NO INTERFERENCE UNABLE TO CARRY ON ANY ACTIVITIES

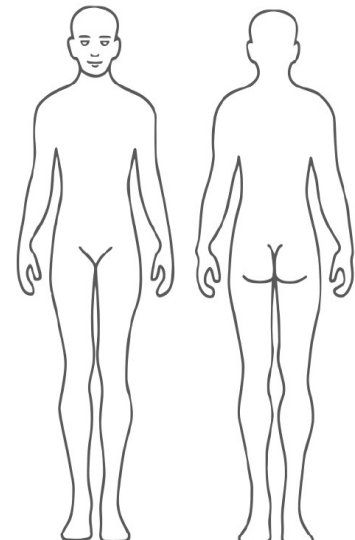
Have you had spinal x-rays, MRI, CT scan for your area(s) of complaint?  No  Yes Date taken \_\_\_\_\_

What areas \_\_\_\_\_

Please circle the areas to the right where you have pain or other symptoms:

**What does it feel like? (check where appropriate)**

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramping
- Nagging
- Sharp
- Shooting
- Burning
- Throbbing
- Stabbing
- Swelling
- Other \_\_\_\_\_



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

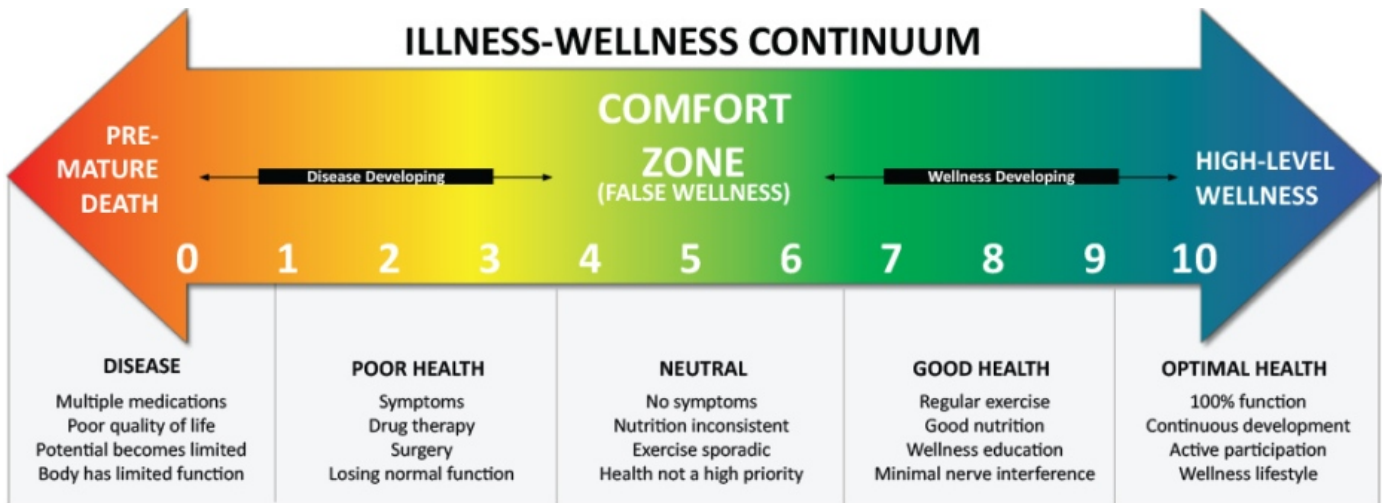
### IMPACT OF YOUR SYMPTOMS

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

1 NOT COMMITTED
  2
  3
  4
  5
  6
  7
  8
  9
  10 VERY COMMITTED

### PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today?

\_\_\_\_\_

B. In what direction is your health currently headed?

\_\_\_\_\_

What are your health goals?

IMMEDIATE

\_\_\_\_\_

SHORT TERM

\_\_\_\_\_

LONG TERM

\_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### CHILDREN & PREGNANCY

How many children do you have? \_\_\_\_\_ Are you currently pregnant?  No.  Yes, I am due \_\_\_\_\_

Children's ages? \_\_\_\_\_ Number of past pregnancies? \_\_\_\_\_

Children's health concerns? \_\_\_\_\_ Health concerns regarding this pregnancy? \_\_\_\_\_

### HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Circulation Issues  | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism            | <input type="checkbox"/> Childhood Illness   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Scoliosis       |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Depression  | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis      | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Hip Issues          | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Digestive Issues<br><small>(Constipation/Diarrhea/GERO/IBS)</small> | <input type="checkbox"/> Immune Issues       | <input type="checkbox"/> TMJ Issues      |
| <input type="checkbox"/> Asthma/Allergies      | <input type="checkbox"/> Elbow/Wrist/Hand Issues   | <input type="checkbox"/> Lymphatic Issues    | <input type="checkbox"/> Urinary Issues  |
| <input type="checkbox"/> Back Pain             | <input type="checkbox"/> Endocrine Issues  | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> (Thyroid)   | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Foot/Ankle Issues   | <input type="checkbox"/> Reproductive Issues | <input type="checkbox"/> _____           |

### ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (List)

MEDICATIONS (List)

SUPPLEMENTS (List)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Have you experienced chiropractic care before? Yes / No	If yes, was it a positive / negative or neutral experience?
What percent of your diet consists of fruits and vegetables?	%
How many ounces of water do you consume on average, daily?	ounces
How much alcohol do you consume?	None / Once in a while / Weekly / Daily / Multiple times per day
Do you smoke?	None / Once in a while / Weekly / Daily / Multiple times per day
Do you exercise?	None / Once in a while / Weekly / Daily / Multiple times per day
Are you healthier now than you were 5 years ago?	
List any surgeries:	
Any family history of?	Diabetes / Heart Disease / Cancer / Rheumatoid Arthritis / High Blood Pressure
When do you generally feel your worst?	A.M / Noon / P.M.
How committed to your health are you? Not	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10         Extremely

**ASSIGNMENT, AUTHORIZATION AND FINANCIAL AGREEMENT**

I hereby consent to a chiropractic evaluation and examination, x-ray(s), chiropractic treatment(s), decompression, k-laser, supplements, healthy lifestyle information (books, CD's, DVD's, etc.), or activities of daily living information rendered to the client which our doctors may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Stanlick Chiropractic. I hereby authorize the above named doctor(s) to release information requested on this form, and I further authorize release of any and all medical records or other pertinent information necessary to obtain payment. I know I am responsible for payment of my account, and I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductible, coinsurances and co-pays are my responsibility to pay.

**TERMS**

Net 30 days from the date of the invoice unless otherwise indicated above. A finance charge of 1.5% per month (annual percentage rate 18%) of unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee and all legal fees of collection, with or without suit, including attorney fees and court costs.

**NOTICE OF PRIVACY PRACTICES**

The federal government has passed the Health Insurance Portability and Accountability Act ("HIPAA") to protect your Personal Health Information ("PHI"). HIPAA took effect on April 14, 2003. Implementation of ,and compliance with, HIPAA is not an option for Stanlick Chiropractic.

Sign below indicating that you have had the opportunity to receive a copy. It will be a permanent part of your medical record. If you are a parent or personal representative of a patient, we will need an Acknowledgment Form signed by you on behalf of the patient.

*By signing below, I acknowledge that I have received and reviewed the Privacy Notice of: Stanlick Chiropractic and all my questions have been answered to my satisfaction in language that I can understand.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Witness \_\_\_\_\_

## CONSENT FOR CHIROPRACTIC CARE

I hereby request that Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Taylor Marsh, D.C., and/or Garrett Webb, D.C. provide chiropractic services for me (or my minor child, whose name appears below). I understand that the care is to be provided by Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Taylor Marsh, D.C., Garrett Webb D.C. and/or designated assistant. Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Taylor Marsh, D.C., and/or Garrett Webb, D.C. has discussed my care with me, and I understand that:

1. **The purpose of chiropractic care is to contribute to health by the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.**
2. **Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis of medical conditions is not a primary goal. However, I will be informed of abnormal findings.**
3. **Chiropractors do not give medical advice, nor do they discourage me from receiving medical advice. If deemed advisable Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Taylor Marsh, D.C., and/or Garrett Webb, D.C. will refer me for medical services with all possible diligence.**
4. **Mitch Stanlick, D.C., Jeremy Bills, D.C., Cash McMeans, D.C., Mark E. Crowell, D.C., Taylor Marsh, D.C., and/or Garrett Webb, D.C. uses only chiropractic methods that are taught in accredited colleges, and appropriate techniques will be selected for my spine care based upon standard professional protocols.**
5. **Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.**
6. **Although the risks are very minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.**
7. **Because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.**
8. **I am an active participant in my chiropractic care, and I am therefore invited to ask any questions or express any concerns that I may have.**
9. **I am free to withdraw my consent and discontinue care at any time.**

## CONSENT TO EVALUATE AND TREAT A MINOR – \*Only pertains if filled out on behalf of minor

By signing below, I, \_\_\_\_\_ being the parent/legal guardian of \_\_\_\_\_ do hereby grant permission to the treating staff doctor to perform chiropractic services to the minor listed above.

*I have read the above statements and understand Stanlick Chiropractic's objectives pertaining to my care in this office.*

Signing below on behalf of minor

Signing below on behalf of self

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Witness (printed) \_\_\_\_\_