



Blue Hills Chiropractic New Patient Form: Adult

1356 2nd Ave., Cumberland
715.822.2500

11 E Marshall St., Rice Lake
715.475.1700

Name: _____ Date: _____ Referred By: _____
 Address: _____ City: _____ State: _____ Zip code: _____
 Home Phone: _____ Cell Phone: _____ Email: _____
 Date of Birth: _____ Age: _____ Gender: _____ Social Security: _____
 Employer: _____ Occupation: _____ Work Phone: _____
 Marital Status: M S W D Spouse: _____ Occupation: _____
 Number of Children, Names & Ages: _____
 Primary Care Physician: _____ Clinic Name: _____
 When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care here? Y N
 Primary Insurance: _____ Secondary Insurance: _____

History of Present Illness

Is your visit for wellness care? Y N

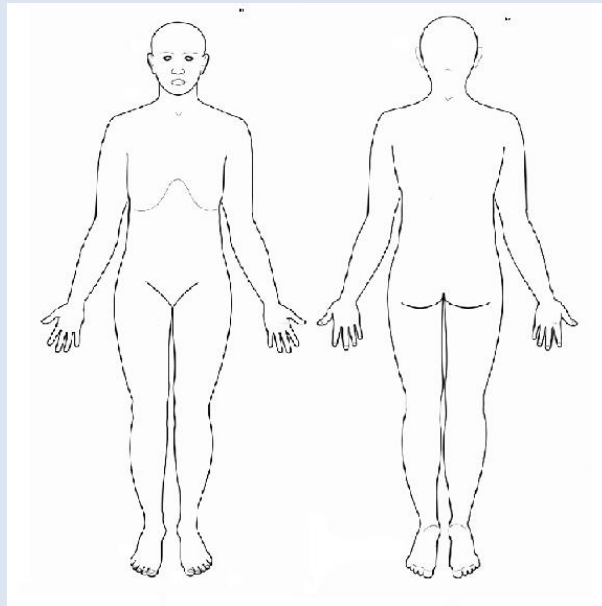
Chief Complaint: _____

Date symptoms began: _____ Due to: Auto Work Other: _____

Have you experienced similar symptoms before? Y N If yes, when? _____

Indicate where & type of pain

- Ache >>>>
- Numb =====
- Pins & Needles ooo
- Burn XXX
- Stabbing ////
- Throbbing ~~~~
- Radiating Pain, use arrows



DOCTOR USE ONLY

Setting: AM
MIDDAY
PM

Progression: WORSE
BETTER
SAME

CONSTANT _____
COME & GO _____

Please Rate your current pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

What makes this pain worse: _____ What makes this pain better _____

Have you seen any other health care providers for this complaint? Y N If yes, who: _____

Results: _____ Were X-Rays or other imaging taken? _____

Please check any of the following activities which the pain affects:

- | | | | |
|-----------------------------|-----------------------|----------------|--------------------------|
| _____ Lying on back | _____ Gripping | _____ Pushing | _____ Bending forward |
| _____ Lying on side | _____ Reaching | _____ Kneeling | _____ Standing for >1hr |
| _____ Turning over in bed | _____ Climbing stairs | _____ Sleeping | _____ Cough/Sneeze/Grunt |
| _____ Getting in/out of car | _____ Dressing Self | _____ Sitting | |
| _____ Lying flat on stomach | _____ Sexual activity | _____ Walking | |

Past Medical History

Please list all injuries, major illnesses, surgeries, falls, auto accidents, or hospitalizations

Injury/Illness	Date	Treatment	Residual Symptoms
1.			
2.			
3.			
4.			
5.			

Have you ever had chiropractic care? Y N When? _____ If yes, who did you see? _____
What were the results? _____

Please check each of the conditions you have currently, or have had in the past:

- | | | |
|-----------------------------------------------|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Low Back pain | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Shoulder/Arm pain | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Ringing of ears | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Congested Sinus | <input type="checkbox"/> Arthritic pain | <input type="checkbox"/> Irregular Menstrual flow |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Breast soreness/lumps |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Asthma | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Knee/Foot pain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Swelling | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gallbladder/Kidney Problems |

Please list any current medications or supplements: _____

Date of last (gynecological/breast) or (testicular/prostate) exam: _____ Was everything normal? Y N

Please circle if you have a family history of:

Cancer Heart Disease Diabetes Stroke Epilepsy Migraines Back pain

Social Health History

How many hours a week do you work? _____ Do you enjoy your job? Y N Hours of sleep per night: _____

Do you exercise? Y N How often? _____ Type of exercise: _____

Do you drink caffeine? Y N Amount per week: _____ Do you drink Alcohol? Y N Amount per week: _____

Do you use tobacco? Y N #__ per: day week (circle one) How much water do you drink per day? _____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Patient Signature: _____ Date: _____

Informed Consent

Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed in consenting to treatment.

Stroke is the most serious complication of chiropractic treatment. It is, on rare occasions, due to injury of the vertebral artery caused by a cervical spine adjustment or manipulation, and when occurs, may cause temporary or permanent brain dysfunction. On extremely rare occasions death occurs. Because the vertebral arteries, which supply the brain with blood, are located within the bones of the cervical spine, cervical treatment poses a small risk. The chances of this occurring are estimated at 1 per 400,000 to 1 per 10 million treatments. The most recent studies (Journal of the CCA, Vol. 37, No. 2, June, 1993) Estimate that incidence of this type of stroke is 1 in every 3 million upper cervical adjustments. Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor of chiropractic if you experience soreness or discomfort. Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury. Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment testing and evaluation are performed carefully to minimize risk. Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but should be reported to your doctor of chiropractic or staff if they occur. There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor of chiropractic promptly.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions concerning the above, please ask your doctor of chiropractic. When you have full understanding and consent to have care provided, please print your name and sign and date below.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Printed Name: _____

Signature: _____ **Date:** _____

Authorization & Release

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information: _____

Signature: _____ **Date:** _____

May we send you mail that may allow others to see that you are a patient of Blue Hills Chiropractic, such as appointment reminder postcards, or invitations to special events? Y N (circle one) Initials: _____

When we call, may we leave information about current appointments you have with Blue Hills Chiropractic on your voicemail or answering machine? Y N (circle one) Initials: _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situation that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

-You may request restrictions on your disclosures.

-You may inspect and receive copies of your records within 30 days with a request

-You may request to view changes to your records

-In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.

-Obtain payment from third party payers

-Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand the Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request in writing, that you restrict how my personal information is used and or disclosed.

Printed Patient's Name: _____

Patient Signature: _____ Date: _____