

Welcome to New Life Chiropractic

Please Print Clearly and Fill in Completely.

Print Name _____ Email _____ @ _____

Street Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Who may we thank for referring you / how did you hear of our office? _____

Were you injured in an automobile accident? YES NO Were you injured at work? YES NO

Please Check

Sex: Male Female Right Handed Left Handed

Health History:

Reason for seeking Chiropractic Care: _____

Describe any health problems, including how long you've had them: _____

Have you seen any other doctor for this problem? YES NO Name: _____

Were you referred by any doctor? YES NO Name: _____

Name, Phone# & Address of PCP: _____

List any medications: _____

Family History:

At our office we are not only interested in your health and well-being, but also the health and well-being of you family and loved ones.

Spouse's Name: _____

Children Names/Ages: _____

Parents Health History: _____

Siblings Health History: _____

Chiropractic History:

Have you ever been to a chiropractor before? YES NO If yes Doctor's Name: _____

Date of last Chiropractic visit _____ Reason for care _____

Date of last Chiropractic X-rays _____ How long were you under care? _____

Are other family members under Chiropractic Care? YES NO Who? _____

Current Complaint:

I would describe the pain as: sharp dull achy comes & goes travels constant

Since the problem started, it is: about the same getting better getting worse

What makes it worse? _____

It interferes with: work sleep walking sitting hobbies leisure

Childhood History (prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

1. Did you have any childhood illnesses? 1.YES [] NO []
2. Did you have any serious falls as a child? 2.YES [] NO []
3. Did you play any youth sports? 3.YES [] NO []
4. Did you have any surgery? 4.YES [] NO []
5. Prolonged use of medications? (i.e. antibiotics, inhalers, etc.) 5.YES [] NO []
6. Any car accidents? 6.YES [] NO []
7. Any major falls? (i.e. tree, seesaw, crib etc.) 7.YES [] NO []
8. Were you vaccinated? 8.YES [] NO []
9. Were you under regular Chiropractic care? 9.YES [] NO []

Adult History (age 18 to present)

10. Do/did you smoke? 10.YES [] NO []
11. Do/did you drink alcohol? 11.YES [] NO []
12. Do/did you play adult sports? 12.YES [] NO []
13. Did you have any surgery? 13.YES [] NO []
14. Any car accidents? 14.YES [] NO []
15. Any work injuries? 15.YES [] NO []
16. Prolonged use of medications? (i.e. antibiotics, inhalers, etc.) 16.YES [] NO []
17. On a scale of 1=none to 10=severe, rate your level of stress at home ___ work ___
18. On a scale of Poor, Good, Excellent: Describe your:
Diet ___ Exercise ___ Sleep ___ General Health ___
19. Do you:
Drink water? YES [] NO []
Belonged to a health club? YES [] NO []
Consumed vitamins or supplements? YES [] NO []

Wellness Commitment

At New Life Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 30% 40% 50% 60% 70% 80% 90% 100%

Insurance Information (if applicable)

Name of insured: _____ Date of Birth: _____
Insurance Company: _____ Phone#: _____
ID# _____ Policy #: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to New Life Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name: _____ Signature: _____ Date: _____

Guardian's Name: _____ Signature: _____ Date: _____



Consent to Initiate Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same health 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 subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being and not merely the absence of disease or infirmity. (from the World Health Organization)

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to 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 or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, 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 a health care provider who specializes in that area. 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 subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All the questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize and consent that the Doctor chooses and employs such assistance as he or she sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given. I agree to pay for all services rendered in this office.

Signature

Date