# chiropractic

*Bringing Out The Best In You!*

## New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

SS # _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? ❍ no ❍ yes Work # _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

## What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us who _____ Phone # _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

This form continues. Please turn the page.

## Current Health

What are your pressing health concerns? _____

_____

_____

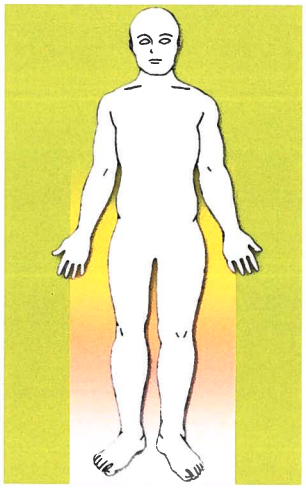
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

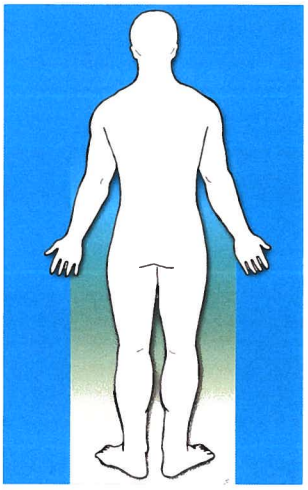
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain _____

_____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain _____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

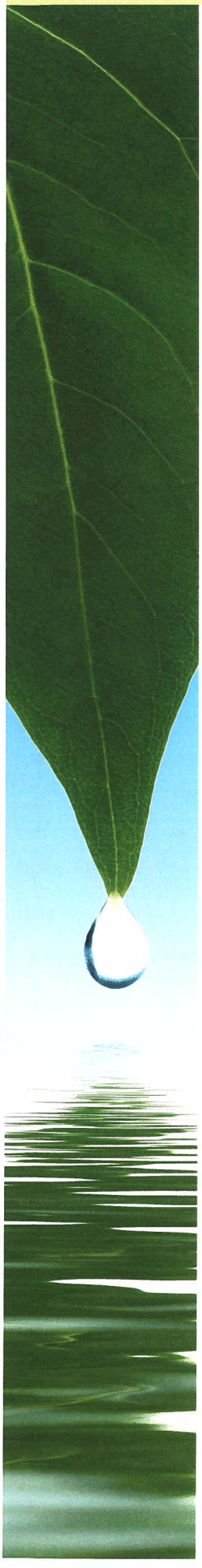
Please explain _____

_____

_____

**On a scale of 1-10 (1 least, 10 most), please rate:**

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10



## Health History

Do you have, or have you had, any of the following (please check ✓ all that apply)?

| | | | | |
|---|---|---|---|---|
| ❍ pneumonia | ❍ mumps | ❍ influenza | ❍ rheumatic fever | ❍ smallpox |
| ❍ pleurisy | ❍ polio | ❍ chickenpox | ❍ thyroid disease | ❍ diabetes |
| ❍ epilepsy | ❍ cancer | ❍ depression | ❍ whooping cough | ❍ anemia |
| ❍ eczema | ❍ measles | ❍ arthritis | ❍ heart disease | ❍ rashes |
| ❍ colitis | ❍ stroke | ❍ allergies _____ | | |

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you drink ❍ coffee ❍ tea ❍ alcohol

Do you use ❍ cigarettes ❍ recreational drugs ❍ artificial sweeteners ❍ sugar

Have you ever suffered from (please check ✓ all that apply)

| | | |
|---|---|---|
| ❍ neck pain | ❍ difficulty breathing | ❍ discolored urine |
| ❍ low back pain | ❍ stuffy nose | ❍ gas/bloating after meals |
| ❍ headache | ❍ fainting | ❍ heartburn |
| ❍ migraines | ❍ weight loss | ❍ irritable bowel |
| ❍ arm pain/tingling | ❍ poor appetite | ❍ black or bloody stools |
| ❍ shoulder pain | ❍ excessive appetite | ❍ constipation |
| ❍ hand pain/tingling | ❍ nervousness | ❍ hemorrhoids |
| ❍ leg pain/tingling | ❍ confusion | ❍ liver problems |
| ❍ jaw pain | ❍ depression | ❍ paralysis |
| ❍ chest pain | ❍ dental problems | ❍ numbness |
| ❍ lung problems | ❍ excessive thirst | ❍ fatigue |
| ❍ heart problems | ❍ frequent nausea | ❍ dizziness |
| ❍ abnormal blood pressure | ❍ prostate problem | ❍ loss of sleep |
| ❍ irregular heartbeat | ❍ breast pain/lump | ❍ difficulty hearing |
| ❍ ankle swelling | ❍ cramps | ❍ ear pain |
| ❍ cold extremities | ❍ painful urination | ❍ other _____ |
| ❍ blurred vision | ❍ bladder trouble | _____ |
| ❍ vision problems | ❍ excessive urination | _____ |

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check ✓ all that apply)

| | | | |
|---|---|---|---|
| ❍ falls/accidents | ❍ head injuries | ❍ fights | ❍ surgery |
| ❍ sports injuries | ❍ broken bones | ❍ dislocations | ❍ other |
| ❍ spinal tap | ❍ knocked unconscious | ❍ traction | _____ |
| ❍ use(d) a cane or walker | ❍ extensive dental work | ❍ dental applications | _____ |

If yes to any of the above, please describe _____

_____

_____

_____

_____

## What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

_____

_____

_____

_____

_____

_____

_____

## Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? ❍ Cash ❍ Check ❍ Credit Card

Credit card # (last 4 digits only) _____ Expiration Date _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

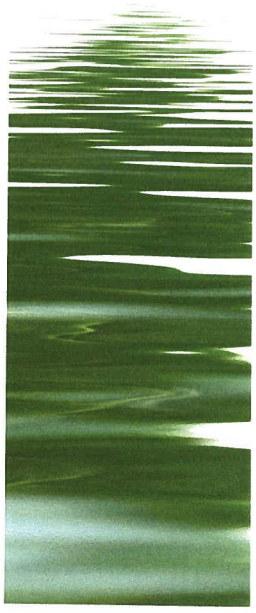
_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)



# Marcotte Family Chiropractic

## TERMS OF ACCEPTANCE

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 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 specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well being, 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 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. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. 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 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. However, we may use other procedures to help your body hold the adjustments.

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

All 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.

_____ _____
(signature) (date)

**Consent to evaluate and adjust a minor child**

I, _____, being the parent or legal guardian

of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Pregnancy Release**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period:
_____

_____ _____
(signature) (date)

**Insurance Release**

I hereby authorize the above named Doctor or Clinic to furnish information concerning my present illness or injury and DIRECT the Insurer to pay without equivocation, directly to the above named Doctor or Clinic any and all benefits due them as a result of this claim. I am also aware that I am personally responsible for charges and/or balance not covered by any insurance. I hereby state and agree that a photocopy of this document will be as valid and binding on all parties involved as the original copy.

_____ _____
(signature) (date)