GEAUX CHIRO
CHIROPRACTIC & HEALTH

**(OFFICE USE)** Scanned: □HSQ □ID □Ins (□ABN □AG □LoG) □AAQ/S&F

Date: _____

# NEW PATIENT HEALTH REVIEW

Last: _____ First: _____ Middle Initial: _____ Sex: □ M □ F

Mailing Address: _____ City/State/Zip: _____

Cell Phone: _____ **Would you like to receive appointment reminders via text? Carrier:_____**

Email: _____ (for receipts, updates, promos, etc.)

DOB:_____ Age: _____ Social Security # (*required*):_____

Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's or Parent's Employer : _____ Position: _____

Business Address:_____ Phone: _____

Name of Spouse: _____

Spouse's Employer: _____ Phone:_____

Emergency Contact:_____

Whom may we thank for referring you? _____

Reason for visit: _____

When did your symptoms appear? _____

Is this condition progressively getting worse? □ yes □ no □ unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: (check all that apply)

□ sharp □ dull □ throbbing □ numbness □ aching □ shooting □ burning □ tingling □ cramps

□ stiffness □ swelling □ other: _____

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your (check all that apply): □ work □ sleep □ daily routine □ recreation

Activities or movements that are painful to perform:

□ sitting □ standing □ walking □ bending □ lying down

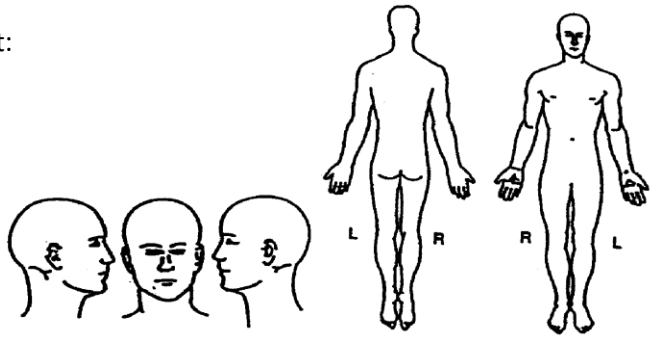
What other health care have you received for this problem?

□ medication □ surgery □ physical therapy □ chiropractic services □ None

□ other: _____

Other doctor(s) who have treated you for this condition. _____

Please mark on the picture the area of discomfort:



Is this condition due to an accident? □ Yes (Date: _____) □ No

**If yes…**

Type of accident: □ auto □ work □ home □ sports □ other: _____

To whom have you made a report of your accident?

□ Auto Insurance □ Employer □ Worker's Comp. □ Other: _____

Attorney name (if applicable):_____

Have you lost any time from work? □ yes □ no Dates: _____

**Personal History:**

Circle YES or NO to indicate if you have had or currently have any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Y N | Goiter | Y N | Parkinson's Disease | Y N |
| Alcoholism | Y N | Gonorrhea | Y N | Pinched Nerve | Y N |
| Allergy Shots | Y N | Gout | Y N | Pneumonia | Y N |
| Anemia | Y N | Heart Disease | Y N | Polio | Y N |
| Anorexia | Y N | Hepatitis | Y N | Prostate Problem | Y N |
| Appendicitis | Y N | Hernia | Y N | Prosthesis | Y N |
| Arthritis | Y N | Herniated Disc | Y N | Psychiatric Care | Y N |
| Asthma | Y N | Herpes | Y N | Rheumatoid Arthrosis | Y N |
| Bleeding Disorder | Y N | High Blood Pressure | Y N | Rheumatic Fever | Y N |
| Breast Lump | Y N | High Cholesterol | Y N | Scarlet Fever | Y N |
| Bronchitis | Y N | Kidney Disease | Y N | STD | Y N |
| Bulimia | Y N | Liver Disease | Y N | Stroke | Y N |
| Cancer | Y N | Measles | Y N | Suicide Attempt | Y N |
| Cataracts | Y N | Migraine Headaches | Y N | Thyroid Problems | Y N |
| Chemical Dependency | Y N | Miscarriage | Y N | Tonsillitis | Y N |
| Chicken Pox | Y N | Mononucleosis | Y N | Tuberculosis | Y N |
| Diabetes | Y N | Multiple Sclerosis | Y N | Tumors, Growths | Y N |
| Emphysema | Y N | Mumps | Y N | Typhoid Fever | Y N |
| Epilepsy | Y N | Osteoporosis | Y N | Ulcers | Y N |
| Fracture | Y N | Pacemaker | Y N | Vaginal Infections | Y N |
| Glaucoma | Y N | | | Whooping Cough | Y N |
| Other: | | | | | |

**Family History:**

| | Cancer | Diabetes | Heart Trouble | High Blood Pressure | Stroke | Kidney Disease | Anemia | Mental Illness | Headaches | Osteoporosis | Arthritis | Joint Problems | Scoliosis | Back Problems | Disc Problems | Congenital Defects | Genetic Disease | Other | Deceased |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | |
| Brothers | | | | | | | | | | | | | | | | | | | |
| Sisters | | | | | | | | | | | | | | | | | | | |
| Children | | | | | | | | | | | | | | | | | | | |

| Exercise: | Work Activity: | Habits: |
|---|---|---|
| □ None | □ Sitting | □ Smoking (Packs/Day _____) |
| □ Moderate | □ Standing | □ Alcohol (Drinks/Week _____) |
| □ Daily | □ Light Labor | □ Coffee/Caffeine Drinks (Cups/Day _____) |
| □ Heavy | □ Heavy Labor | □ High Stress Level (Reason _____) |

**LADIES**: Are you pregnant? □ yes (Due Date: _____) □ no

**Injury/Surgery History:**

| | **Description** | **Date** |
|---|---|---|
| **Falls** | _____ | _____ |
| | _____ | _____ |
| **Head Injuries** | _____ | _____ |
| | _____ | _____ |
| **Broken Bones** | _____ | _____ |
| | _____ | _____ |
| **Dislocations** | _____ | _____ |
| | _____ | _____ |
| **Surgeries** | _____ | _____ |
| | _____ | _____ |

| **Medications:** | **Allergies:** | **Vitamins/Herbs/Minerals:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Pharmacy Name & Phone #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This consent will end when my current treatment plan is complete or five years from the date signed below.

Signature: _____ Date: _____

# Daily Activity Restrictions

Patient Name:_____ Date:_____

*Circle each that applies*

| **Routine activities** | **Difficulty/Pain** | **Unable to perform** |
|---|---|---|
| Bathing | Y / N | Y / N |
| Getting in/out of the bath tub | Y / N | Y / N |
| Getting on/off the toilet | Y / N | Y / N |
| Shampooing and/or grooming your hair | Y / N | Y / N |
| Putting on/taking off your shoes | Y / N | Y / N |
| Putting on/taking off your clothes | Y / N | Y / N |
| Brushing your teeth | Y / N | Y / N |
| Cleaning | Y / N | Y / N |
| Carrying large loads (groceries/laundry/garbage) | Y / N | Y / N |
| Cooking | Y / N | Y / N |
| Washing the car | Y / N | Y / N |

| **Postural Activities** | **Difficulty/Pain** | **Unable to perform** |
|---|---|---|
| With prolonged sitting | Y / N | Y / N |
| With prolonged standing | Y / N | Y / N |
| With prolonged walking | Y / N | Y / N |
| Climbing the stairs | Y / N | Y / N |
| Crawling | Y / N | Y / N |
| Bending | Y / N | Y / N |
| Laying on your stomach | Y / N | Y / N |
| Laying on your back | Y / N | Y / N |
| Kneeling | Y / N | Y / N |
| Squatting | Y / N | Y / N |

| **Driving Activities** | **Difficulty/Pain** | **Unable to perform** |
|---|---|---|
| Turning your head | Y / N | Y / N |
| Rotating your body | Y / N | Y / N |
| When driving | Y / N | Y / N |

| **Recreational Activities** | **Difficulty/Pain** | **Unable to perform** |
|---|---|---|
| Participating in aerobic activities/sports | Y / N | Y / N |
| Running or Jogging | Y / N | Y / N |
| Weightlifting | Y / N | Y / N |

| **Sleep Habits** | |
|---|---|
| Take longer to fall asleep | True / False |
| Sleep is interrupted | True / False |
| Cannot fall asleep without medication | True / False |

I have read the above questions and answered to the best of my knowledge.

_____

Patient Signature

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Geaux Chiro Chiropractic & Health's Notice of Privacy Practices for protected health information.

_____

Patient Name Printed Date_____

_____

Signature of Patient/Personal Representative

**(FOR OFFICE USE ONLY – Please do not sign below this line)**

***Documentation of Good Faith Effort to Obtain Written Acknowledgement***

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the patient the Notice of Privacy Practices posted in our office.
- ☐ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ☐ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ☐ Asking the patient to sign this Acknowledgement form.
- ☐ Other (explain in detail) _____

_____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form.
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail) _____

_____

Date: _____ Name:_____

**Notes:** This written acknowledgement must be completed no later than the first date health care service or treatment is provided to the patient. This acknowledgement must be retained in the patient's permanent records.

# Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intent this consent form to cover the procedures for my condition and for any future conditions for which I seek treatment.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by the patient

_____

Witness

# Insurance

We welcome you as a new patient and want you to be clear on your financial responsibility for care at our clinic.

If you have health insurance, we will call and verify your coverage. This will be explained to you and the terms of your coverage will be in your chart. You will be responsible for any non-covered expenses such as ice packs, vitamins, back braces, pillow, etc. You are also responsible for any and all costs associated with your deductible and co-payments. You can pay this on each visit or on a monthly basis.

As a courtesy, this office will provide you with your insurance benefits and will file all insurance claims. Please note that you will either have a copay or will be required to pay towards your deductible at each visit. If your deductible has been met, most insurance companies will cover a percentage of treatment billed. Once you have met your out of pocket maximum, most insurance companies will cover 100% of all eligible expenses for the remainder of the calendar year. If there is a question about your personal balance, please feel free to contact us at your convenience. Please note that this may be done by telephone, or feel free to do this at the time of one of your therapy sessions.

Please sign and date this letter station that you are aware of your insurance benefits and that you know that you will be required to pay all co-pays, unmet individual deductibles, and out of pocket maximums at the time that services are rendered.

_____ _____

Patient's Signature Date

_____ _____

Office Assistant Date