Confidential Information & New Patient Application

Name: _____ **Prefer To Be Named:** _____ **Cell Phone:** _____

Address: _____ **City/State:** _____ **Zip Code:** _____

Age: _____ **Birth Date:** _____ **Home Phone:** _____ **Marital Status: M S W D**

Race: _____ **Ethnicity:** _____ **Language(s):** _____ **SS#:** _____

My Email is: _____

Occupation: _____ **Employer:** _____ **Office Phone:** _____

Insurance Company: _____ **Policy #:** _____

Policy Holder: _____ **Policy Holder DOB:** _____

Name of Husband or Wife: _____ **Occupation:** _____

Employer: _____ **Office Phone:** _____

Emergency Contact: _____ **Relationship**: _____ **Phone:** _____

Whom may we send a 'Thank You!' to for referring you to our office? _____

Current Health History

Area of Complaint/s: _____

Date Problem Began: _____ **How did your problem begin?** _____

How would you describe the pain? □ Sharp □ Dull □ Diffuse □ Achy □ Burning □ Shooting □ Stiff □ Numb
□ Tingly □ Sharp w/motion □ Shooting w/motion □ Stabbing with motion □ Electric like w/motion

Does the pain radiate? □ Localized to spine □ Radiates below elbow or knee □ Radiates to face □ Other

Using a scale from 0-10 (10 being the worst), how would you rate your problem? 1 2 3 4 5 6 7 8 9 10

My Condition is: □ Getting Worse □ Staying the same □ Getting Better

How often do you experience your condition?

□ Constantly (76-100%) □ Frequently (51-75%) □ Occasionally (26-50%) □ Intermittently (1-25%)

How much has the problem interfered with your normal daily activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

How much has the problem interfered with your work/required tasks?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely □ Do not work

Have you had anything like this before? □ Yes □ No How many times? □ 0-3 □ 4-5 □ > 5

Do you have a history of spinal surgery? □ Yes □ No Does this area still bother? □ Never □ < 2/year □ >2/year

Do you consider your problem to be severe? □ Yes □ Yes, at times □ No

What aggravates your problem? _____

What makes your problem feel better? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

Who else have you seen for your problem? □ Chiropractor □ Neurologist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Massage Therapist □ Physical Therapist □ Other: _____

Who is your primary care physician? _____ **Medical Group:** _____

How would you rate your overall health? □ Excellent □ Very Good □ Good □ Fair □ Poor

What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	Chronic Sinusitis	□	□	Dizziness
□	□	Neck Pain	□	□	High Blood Pressure	□	□	Diabetes
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Excessive Thirst
□	□	Mid Back Pain	□	□	Stroke	□	□	Frequent Urination
□	□	Low Back Pain	□	□	Angina	□	□	Smoking/Tobacco Use
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorder	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Change	□	□	Other: _____
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			_____
□	□	Jaw Pain	□	□	Abdominal Pain			_____
□	□	Joint Pain/Stiffness	□	□	Ulcer	**For Females Only**		
□	□	Arthritis	□	□	Hepatitis	□	□	Birth Control Pills
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Hormonal Replacement
□	□	Cancer	□	□	General Fatigue	□	□	Pregnancy
□	□	Tumor	□	□	Muscular In coordination			
□	□	Asthma	□	□	Visual Disturbances			

List all the prescription medications you are currently taking: _____

_____

List all the vitamins/supplements you are currently taking: _____

_____

List all the surgical procedures you've had: _____

What activities do you do at work?

□ **Sit**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone**	□ Most of the day	□ Half the day	□ A little of the day

What activities do you do outside of work? _____

Have you had any significant past trauma? _____

Anything else we should know? _____

_____

Patient /Guardian Signature: _____ **Date:** _____

THOMPSON VALLEY Chiropractic

Name:_____ Date: _____ DOI: _____

1. What was the date of the accident? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What state did the accident occur in? _____
6. What city did the accident occur in? _____
7. What street or intersection were you on when the accident occurred? _____
8. What direction were you traveling in? _____
9. What type of impact was the auto accident? _____
10. Did your vehicle hit anything after the accident? □No □Yes. If yes, please describe:

_____

11. Where were you sitting in the vehicle during the accident? _____
12. Did you know the accident was coming? _____
13. What type of vehicle were you in? _____
14. What type of vehicle impacted yours? _____
15. At the time of the impact, how fast was your vehicle moving? _____
16. At the time of impact, how fast was the other vehicle moving? _____
17. During and after the crash what happened to your vehicle? (circle all that apply)

-kept going straight	-spun around
-kept going straight hitting a car in front	-spun around and hit a stationery object
-was hit by another vehicle	-hit a stationery object

18. Did you lose consciousness during the accident? □No □Yes
19. How was your head positioned during the accident? _____
20. How was your torso positioned during the accident? _____
21. How were your hands positioned during the accident? _____
22. Did your head hit anything during the accident? □No □Yes, please describe:

_____

THOMPSON VALLEY Chiropractic

Name:_____Date:_____ DOI: _____

23. Did your face hit anything during the accident? □No □Yes, please describe:

_____

24. Did your shoulders hit anything during the accident? □No □Yes, please describe:

_____

25. Did your neck hit anything during the accident? □No □Yes, please describe:

_____

26. Did your chest hit anything during the accident? □No □Yes, please describe:

_____

27. Did your hips hit anything during the accident? □No □Yes, please describe:

_____

28. Did your knees hit anything during the accident? □No □Yes, please describe:

_____

29. Did your feet hit anything during the accident? □No □Yes, please describe:

_____

30. What kind of headrest was in your vehicle?

-movable fixed headrest
-nonmovable fixed headrest
-no headrest

31. Where was the headrest positioned on your head? _____

32. Did you have your seatbelt on during the accident? □No □Yes

33. Did you slide out of your seatbelt during the accident? _____

34. What was damaged in your vehicle? (Circle all that apply)

-windshield	-rear bumper	-mirror
-steering wheel	-front bumper	-knee bolster
-dashboard	-trunk	-back right door
-seat frame	-front left door	-completely totaled
-side window	-front right door	
-rear window	-back left door	

35. Choose the items that dented inward

-floorboards	-side door	-dashboard

36. Choose the doors that would not open as a result of the accident:

-front left	-front right
-rear left	-rear right

37. Did you go to the hospital? If no, why and do not answer questions 38-43.

_____

Name: _____ Date: _____ DOI: _____

If you went to the hospital please complete the following questions:

38. How did you get to the hospital? _____

39. What was the name of the hospital? _____

40. Were you hospitalized overnight? _____

41. Circle what you were prescribed at the hospital:

-pain medication -muscle relaxers -neck brace

42. Did you receive any stitches for any cuts at the hospital? □No □Yes

43. Were x-rays taken at the hospital? □No □Yes If yes, which are was taken?

_____

Personal Injury Insurance Information

Patient: _____ Accident Date:_____

Attorney Information

Name: _____ Phone: _____

Address: _____

Auto Insurance Information

Company _____

Policy #: _____

Claim #: _____

Phone #: _____

Adjustor: _____

Address: _____

_____

Other Party's Insurance Information

Company _____

Policy #: _____

Claim #: _____

Phone #: _____

Adjustor: _____

Address: _____

_____

(For Office Use Only -- Questions to Ask Attorney)

1. Does Liability look questionable? Yes ☐ No ☐
2. Is the insurance policy active and will cover this accident? Yes ☐ No ☐
3. Was a police report filed? Yes ☐ No ☐
4. Were there any witnesses? Yes ☐ No ☐
5. Amount of property damage _____
6. Were there other people in the car? Yes ☐ No ☐ How many? _____
7. Is there Med-Pay? Yes ☐ No ☐ What amount? _____

   Limits? _____

Med-Pay Verified Date _____ Spoke to _____

Initial _____

Informed Consent of Chiropractic Treatment

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at Thompson Valley Chiropractic (TVC). TVC will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to TVC for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that TVC will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to TVC will be credited to my account on receipt.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I hereby authorize TVC to work with my condition through the use of adjustments to my spine, as the Doctor deems appropriate. This consent will cover the entire course of my treatment within this office.

_____ By initialing here I agree to the above and allow the Doctor, affiliated with TVC, to perform such.

Pregnancy Notice

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant, regardless of stage or trimester of pregnancy. If there is a chance you may be pregnant, let the doctor know *immediately*.
Are you pregnant? □ Yes □ No On what date did your last period begin? _____

Ownership of X-Ray Films / Privacy Policies and Procedures

It is understood and agreed that the payments to TVC for X-rays is for examination of X-rays only. The X-ray negative will remain the property of TVC. These are kept on file where they may be seen at any time while I am a patient at TVC.

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 situations 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 request to view changes to your records.
- You may inspect and receive copies of your records within a 30 day request.
- In the future, you may be contacted for appointment reminders, announcements and to inform you about TVC and its team.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 (if applicable).
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read and understand your Informed Consent for Chiropractic Treatment, Pregnancy Notice, and Notice of Ownership of X-Ray Films / Privacy Policies and Procedures. 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.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient or Guardian Signature Relationship to Patient