ALTA CHIROPRACTIC & WELLNESS CENTER NEW PATIENT INFORMATION-PLEASE PRINT LEGIBLY

Name _____ Address _____ Apt. #____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email (Required for MVA)_____

Full SS# or ITIN# (Required for MVA and Insurance Billing) _____

Date of Birth _____ Age ____ Gender _____ Height _____ Weight _____

Number of Children _____ Name of Spouse/Partner/Parent (circle one)_____

Employer _____ Phone _____ Occupation _____

Emergency Contact Name_____ Phone _____ Relation _____

How did you hear about our office? (Please provide a NAME if it was a person) _____

Have you had chiropractic care before? _____ Doctor's name _____ Date of last visit _____

If you are experiencing any pain (neck pain, low back pain, mid-back pain etc.), symptoms, and/or complaints, please list:

1. _____ For how long? _____
2. _____ For how long? _____

Do you have an open worker's compensation case? _____ If yes, please notify the front desk. We are not a work comp provider.

Has this problem been getting worse or staying the same? _____

Are there any activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain:

_____

Have you been involved in an auto accident in the last 12 months? _____ If yes , what was the date of the accident? _____

Do you have an attorney representing you for this auto accident? _____ If yes, who is your attorney? _____

If due to an auto accident, what is the name of your auto insurance company? (Required) _____

Have you filed an auto insurance claim? ☐ Yes ☐ No If yes, what is your claim number? (Required)_____

List other doctors consulted for these conditions: _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: ____Aspirin/Tylenol ___

Pain Medications ____ Muscle Relaxers ____ Insulin ____ Birth Control _____Sleeping Pills ____Anti-Depressants ____

Others (Please list)_____

We would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.

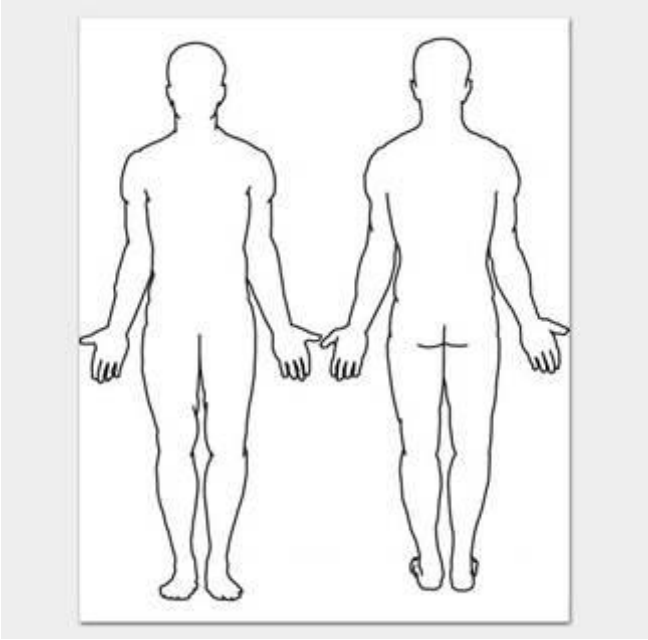
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Completely able to function **Totally unable to function**

1. FAMILY/HOME RESPONSIBILITIES: Activities related to the home or family, including chores and duties performed around the house (yard work, doing dishes, errands, driving children to school, etc.) _____
2. RECREATION/LEISURE ACTIVITIES: Hobbies, sports, social, and other similar leisure activities _____
3. OCCUPATION: Activities that are a part of or directly related to one's job, including non-paying jobs as well, such as that of a homemaker or volunteer work. _____
4. SELF CARE: Activities which involve personal maintenance and independent daily living, including taking a shower, driving, getting dressed, etc. _____

5. LIFE SUPPORT ACTIVITY: Basic life supporting behaviors such as eating, sleeping, and breathing. If you are experiencing health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below.



Informed Consent to Chiropractic Care

I acknowledge that chiropractic care may include spinal and/or extremity adjustments, joint mobilization, and manual or instrument-assisted procedures intended to improve joint function and mobility. Such procedures involve the application of controlled force and may result in joint movement and associated sounds, which are considered normal.

I understand that chiropractic treatment, including procedures involving the cervical spine, involves inherent risks common to physical and manual therapies. The most frequent effects include temporary soreness or stiffness. Less common risks may include muscle or ligament strain, joint or disc irritation, or nerve involvement. I acknowledge that concerns have been raised regarding cervical spine treatment and cerebrovascular events; however, current scientific literature has not established a causal relationship between chiropractic cervical adjustments and stroke. Such events are considered extremely rare, and clinical evaluation and screening procedures are utilized to further reduce potential risk. No screening process, however, can eliminate all risk.

I acknowledge that declining or delaying treatment may result in the continuation or worsening of symptoms, reduced mobility, or progression of the underlying condition. I understand that no guarantee or assurance has been made regarding the results of chiropractic care, and that outcomes may vary among individuals.

I have read and understand the explanation of chiropractic care provided above. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I understand the nature of the proposed care, its potential risks and benefits, and the risks of remaining untreated. I understand that my care may include cervical, thoracic, lumbar, and/or extremity procedures as clinically indicated. This consent applies to current and future care unless revoked. I understand that I may refuse or withdraw my consent at any time.

By signing below, I voluntarily consent to chiropractic care.

Printed name _____ Date _____

Signature _____