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# _____ 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, back pain, etc.), health problems, 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.
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 below)

_____

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.) _____

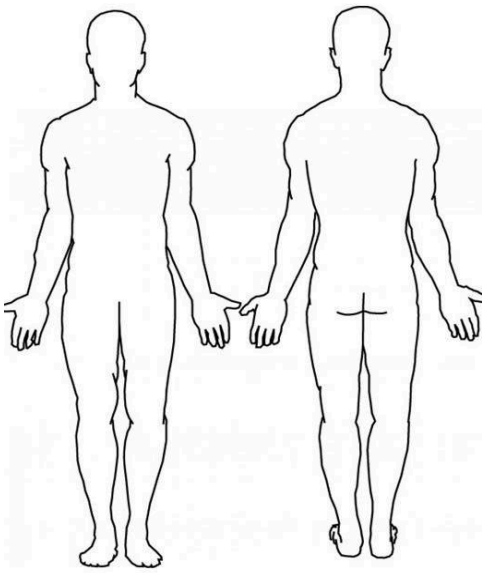
2. RECREATION/LEISURE ACTIVITIES: Hobbies, sports, social, and other similar leisure activities _____

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

The nature of chiropractic care: The doctor will use his hands or mechanical device in order to move your joints. You may feel a "click" or hear a "pop," and you may feel movement of the joint. Possible risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Probability of risks occurring: The risks of complications due to chiropractic care have been described as "rare." The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

I have read the explanation of chiropractic care. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits, and I have freely decided to undergo the treatment. I hereby give my full consent to treatment.

Printed name _____ Date _____

Signature _____