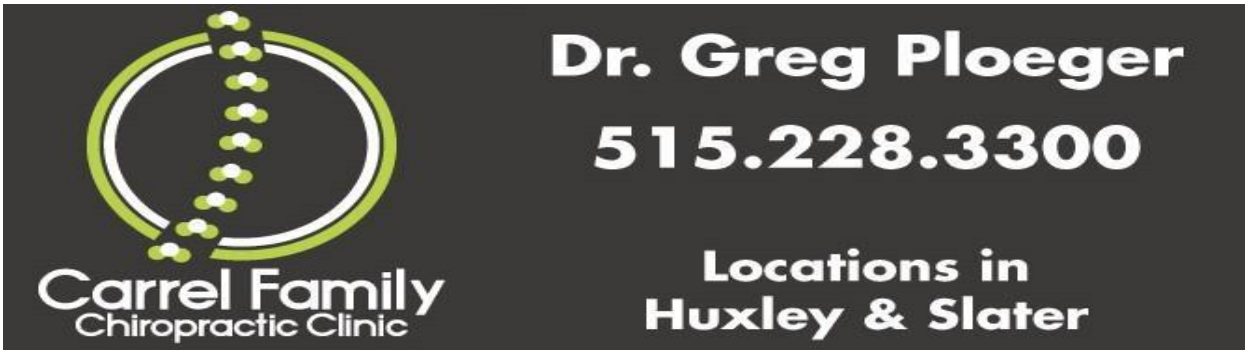


Slater Location:
417 Main Street
Slater, Iowa 50244

Huxley Location:
501 East 4th Street
Huxley, Iowa 50124

New Patient Data

Confidential Patient Health Record Today's Date:___/____/_____

Personal Information

Title: • Mr. • Ms. • Mrs. • Dr. • Rev. • Miss • Prof. • other: _____

Last:_____ First:_____ Middle: _____

Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female

Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ ext _____ Cell Phone: (_____) _____-_____ ext _____

Email Address: _____ Spouses Name: _____

In the event we need to contact you, what is the best method of communication? *Home or Cell Phone* *E-Mail*

Children (Names and Ages): _____

How did you hear about us? **• Family _____ • Friend _____ • Co-Worker _____**

• Close to home/work • Internet/ MFC website • Yellow pages • Drove by • Physician • Insurance Plan

Emergency Contact

Name:_____

Phone # (____) _____-_____Relationship: • Spouse • Relative • Friend • Other _____

Employment Information

Business Name: _____

Occupation/Job Title and Description: _____ _____

***Current Health Condition*: Addressing what brought you to this office: If no symptoms, skip to Review of Systems (p.2)**

Unwanted Condition (Why you are here today?):_____

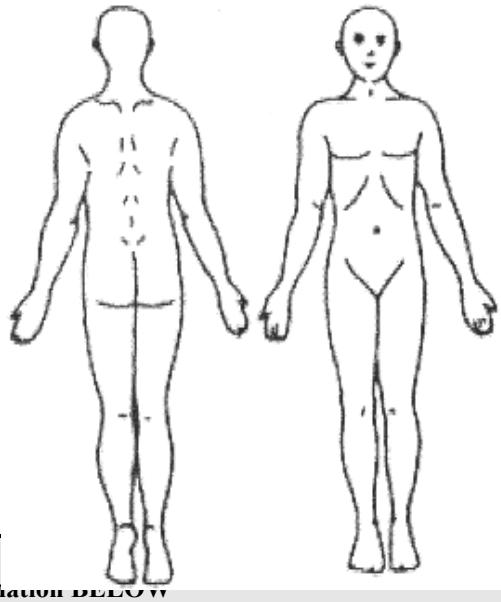
_____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → →

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

Key: A=Ache B=Burning N = Numbness P=Pins & Needles S=Stabbing



How would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10 (worst)

When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? • Yes • No. When? _____

Is the Condition: • Auto Related • Job Related • Home Injury

• Slip or Fall • Lifting • Slept Wrong • Unknown Cause • Other

Explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

Previous Care for this Same Condition:

• NO, I have not previously seen a doctor for this condition OR Fill in the information BELOW

Other doctors seen for this condition: [ ] Chiropractor [ ] Medical Dr. [ ] Other _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? • Yes • No

Explain: _____

***Review of Systems:* CIRCLE all CURRENT and PAST conditions. List any health conditions that are not shown below. Even if a condition seems unrelated to care, please check. These may affect your overall care.**

• ADD/ADHD	• ear infections	• high / low blood pressure	• psychiatric problems
• allergy:_____	• depression	• influenzal pneumonia	• scoliosis
• Alzheimers	• diabetes (insulin dep)	• liver disease	• seizures
• anemia	• diabetes (non-insulin)	• lung disease	• shingles
• arthritis	• eczema	• lupus erythema (discoid)	• past history of similar symptoms
• asthma	• emphysema	• lupus erythema (systemic)	• STD's (unspecified)
• cancer	• eye problems	• multiple sclerosis	• suicide attempt(s)
• cerebral palsy	• fibromyalgia	• Parkinson's disease	• thyroid problems
• chicken pox	• heart disease	• pleural effusion	• tinnitus or vertigo
• crohn's/colitis	• hepatitis	• pneumonia	• dizziness
• CRPS (RSD)	• HIV	• psoriasis	• diarrhea/ constipation:
• CVA (stroke)	• heartburn	• difficulty sleeping	• high cholesterol
• anxiety / stress	• numbness	• fatigue	• frequent colds
• jaw pain	• headaches	• currently pregnant	• osteopenia
• sinus problems	• traumatic birth -your own	• osteoporosis	• vertigo
• Other:	• Other:	• Other:	• Other:

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you taken?

Current Vitamins, Herbs, etc: **List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.**

Type	Dosage	For What Condition, if any?	How long have you taken?

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

- **angioplasty**
- **appendectomy**
- **caesarian section**
- **cardiac catheterization**
- **carpal tunnel repair**
- **coronary artery bypass**
- **cosmetic**
- **D & C**
- **dental surgery**
- **gall bladder**
- **hemorrhoidectomy**
- **hernia repair**
- **hysterectomy**
- **joint reconstruction**
- **joint replacement**
- **knee repair**
- **laminectomy**
- **mastectomy**
- **pacemaker insertion**
- **rotator cuff**
- **spinal fusion**
- **tonsillectomy**
- **other:**
- **other:**

Injury (ies): **Mark or List All Injuries. Write the DATE of the Injury immediately afterward.**

- **back injury**
- **broken bones**
- **disability (ies)**
- **fall (severe)**
- **fracture**
- **head injury (loss of consciousness)**
- **head injury (no loss of consciousness)**
- **industrial accident**
- **joint injury**
- **laceration (severe)**
- **motor vehicle accident**
- **soft tissue injury (mild)**
- **soft tissue injury (severe)**
- **other:**
- **other:**

Family History:

We know that many health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that concern them? Diabetes Heart Disease Cancer Fibromyalgia Stroke Back Pain Other: _____

Social History: **Mark all that apply below.**

- **Alcohol: • do not drink alcohol • social consumption only • drink regularly, quantity of ____glasses per _____**
- **Caffeine: • pop • diet pop • coffee • other _____ Amount:_____**
- **My diet – rate:** (Poor) **1 2 3 4 5 6 7 8 9 10** (Perfect) **Average daily water intake _____**
- **Never Smoker • Former Smoker, years quit: _____ • Someday smoker • Every day smoker, packs/day_____**
- **Sleep Amount: _____ hours per night**

Goals For My Care: *(please read the following thoroughly so you know why these forms are important)*

People see Chiropractors for a variety of reasons. Some go for Relief Care, to address their symptom, disease, or condition. Some go to Correct/Stabilize the cause of their symptom, disease, or condition. And some choose Wellness Care, so they can prevent future problems and maximize their health and well-being. Your Doctor will make optimal recommendations, based on your health and what your body needs. We would like to know what your goals are.

- **Relief Care** – Treatment designed to address an obvious symptom, disease, or condition
- **Stabilization Care** – Continue with the care necessary to fully heal soft tissues and muscles
- **Wellness Care** – Non-symptomatic or maintenance care, designed to maximize optimum spinal and nervous system function and help prevent disease.

With which physician(s) do you want us to coordinate care?

(Circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other

Doctor: _____ **Doctor:** _____

Clinic's Name and Location _____

Financial Policy

I understand that insurance coverage is an agreement between me and my insurance carrier. Carrel Family Chiropractic will assist with submitting claims and credit any insurance payments received to my account. However, I am ultimately responsible for all charges incurred, including services not covered or denied by my insurance company. If I suspend or discontinue treatment, any outstanding balance becomes immediately due and payable.

Consent to Chiropractic Care and Treatment

I hereby request and consent to chiropractic evaluation and treatment, including chiropractic adjustments, physical therapy modalities, diagnostic x-rays, and other procedures deemed appropriate by Dr. Greg and/or other licensed chiropractic providers at Carrel Family Chiropractic, PC.

I understand that chiropractic treatment, like all healthcare procedures, carries certain risks. Potential complications may include, but are not limited to, soreness, sprains, strains, fractures, disc injuries, dislocations, neurological injury, and, in rare cases, stroke. No guarantees have been made regarding the results of treatment.

I understand that the doctor will use professional judgment in determining the appropriate course of care based on the information available at the time of treatment. I agree to inform the doctor of any significant health conditions, including pregnancy, that may affect my care.

I have had the opportunity to ask questions regarding my treatment and understand the nature, benefits, and potential risks of chiropractic care. By signing below, I consent to the recommended treatment and intend this consent to apply to my current condition and any future conditions for which I seek treatment at this office unless revoked in writing.

I acknowledge that I have received and/or been offered a copy of the Practice's Notice of Privacy Practices and understand the policy regarding my protected health information.

Patient Printed Name:_____

PatientSignature:_____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____

Relationship to Patient: _____

HIPAA Consent and Acknowledgment

I consent to Carrel Family Chiropractic's use and disclosure of my Protected Health Information (PHI) for treatment, payment, and healthcare operations. I understand that I have the right to review the Practice's Notice of Privacy Practices, request restrictions on the use of my PHI, and revoke this consent in writing, subject to applicable law.

By signing below, I acknowledge that I have read and understand this consent.

Patient Signature: _____ Date: _____

Printed Name: _____