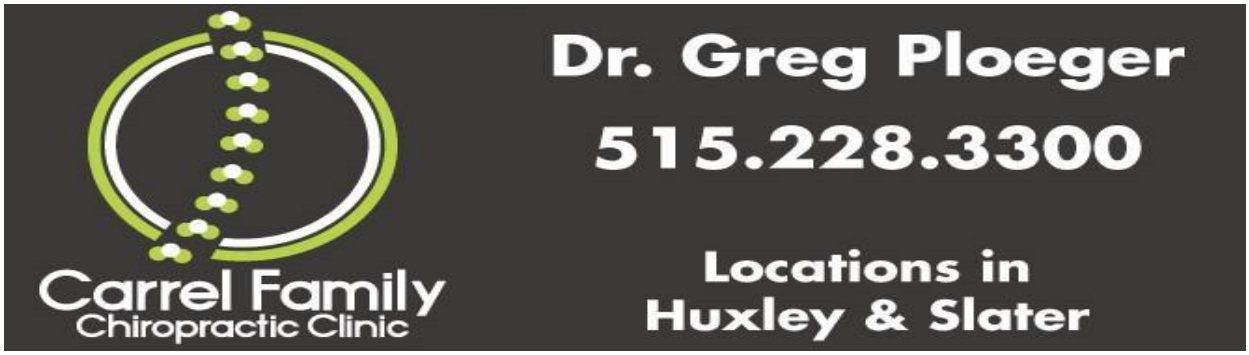


Slater Location:
417 Main Street
Slater, Iowa 50244

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

→ → → → → → →

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: _____

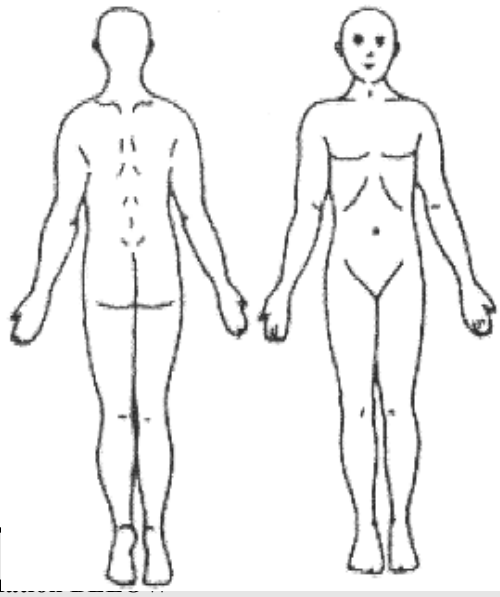
_____

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

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

_____

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



Previous Care for this Same Condition:
• NO, I have not previously seen a doctor for this condition OR Fill in the inform

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 Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Carrel Family Chiropractic 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 Carrel Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for the services provided to me by Dr.Greg. However, I clearly understand and agree that all services rendered to me are my personal responsibility.. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered, will be immediately due and payable.

Informed Consent:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Greg and/or other licensed doctors of chiropractic who now or in the future work at Carrel Family Chiropractic, PC.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received MFC/BFC's 2013 HIPAA notice and understand the policy for my protected health information

Patient Print Name: _____

Patient's Signature: _____

Date: _____

Consent to treat a Minor - Guardian or Parent's Signature of Authorizing Care:

_____

Signature of Other Parent Authorizing Care: _____

Carrel Family Chiropractic
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Carrel Family Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

The Doctor will use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as"Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

The Doctor is aware of these complications, and in order to minimize their occurrence will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. If you are pregnant, you should tell the Doctor when your clinical history is taken.

If you have any questions for the Doctor, you may wait to sign this form until all questions have been answered.

_____ _____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**