# NEW PATIENT QUESTIONNAIRE

**Today's Date:** ____ / ____ / _____

**Your Name:** _____ **[ ] Male [ ] Female [ ] Other** _____

**Date of Birth:** _____ / _____ / _____ **Age:** _____ **Social Security Number:** _____ - _____ - _____

**Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Domestic Partner**

**Home Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Mobile Phone:** (____) _____ **Home Phone:** (____) _____

**Email:** _____ **Work Phone:** (____) _____

**Your Employer:** _____ **Address :** _____

**City:** _____ **State:** _____ **Zip:** _____

**Occupation (if retired, what did you retire from):** _____

**Emergency Contact Name:** _____ **Relationship to Patient:** _____

**Home Phone:** (____) _____ **Mobile Phone:** (____) _____

**Who Referred you to Us?** _____ **Where did you find our Phone Number?** _____

**Internet: [ ] Google [ ] Bing [ ] Yahoo [ ] Yelp [ ] Facebook [ ] Insurance List [ ] Website [ ] Other** _____

**BILLING AUTHORIZATION**

A. I hereby authorize the release of any health care information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any health care benefit from the third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products/services rendered.

C. I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care/treatment, any fees for products or professional services rendered will be immediately due and payable.

**Cancellation Policy:** If you can not make your appointment, your consideration to call and reschedule would be appreciated. The sooner the appointment is rescheduled or cancelled, the greater the possibility for that appointment time to be filled by another patient. **Anyone who fails to show up for an appointment and or does not provide 12 hour notice prior to the scheduled appointment, may be subjected to a fee of $25**. These charges will not and **can not** be billed to your insurance provider.

**Patient Name (Print):** _____ **Date:** _____

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

# *Notice of Privacy Practices*

Dr. Beaman, under the HIPPA Standards of Privacy of Individually Identifiable Health Information (The Privacy Rule), modified on August 14, 2002 will:

- Collect information that is relevant and necessary to carry out our role.
- Explain at the time the information is being collected, why it is needed, and how it will be used.
- Ensure that the records are used only for the reasons given or seek the person's permission when another purpose for their use is considered necessary or desirable.
- Provide adequate safeguards to protect the records from unauthorized access and disclosure.
- Allow people to see the records kept on them and provide them with the opportunity to correct inaccuracies in their records.
- Provide records to an entity, medical doctor or facility in order to coordinate your care.
- Obtain information needed to confirm your insurance benefits and obtain payment for services.
- Release information to your Health Plan at their request for billing of their administrative purpose.
- Release records when they are requested by you or your representative. Release records to certain government authorities as permitted or required by law to investigate or regulate health related issues such as child abuse, communicable diseases and prescription drugs.
- Certain lawyers and parties in a law suit if a patient's medical condition is an issue in a law suit.

The goal of Active Nevada Chiropractic & Wellness is to protect our patients privacy (Private Health Care Information) at the same time providing them with the most efficient and effective care possible.

Please acknowledge you have read and understood the above description and understand that in order to give you the most efficient care any and all records regarding a healthcare issue will be forwarded to the facility or physician we may deem appropriate.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

If you require more information regarding HIPAA regulation please contact this office at (702) 474-6996 or (702) 474-4400 and ask for the HIPPA representative.

# INFORMED CONSENT TO CHIROPRACTIC CARE

As a patient in our office, you have the right to know about the type of treatment we will use, and complications / side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these prior to treatment and receive your written consent for you or your minor child.

The primary treatment used by Chiropractic Physicians is the adjustment or manipulation of the joints of the body to induce motion. The doctor will use the procedure most appropriate to treat your condition as well as ancillary treatments such as prescribing exercises, and using therapeutic modalities.

**The nature of the Chiropractic Adjustment**: I will use my hands and/ or a mechanical device upon your body in such a way as to move the joints to restore normal function. This procedure may cause an audible "click" or "pop" sound similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, which usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there is other less forceful and gentler type of adjustments that may be used.

**The possible risk involved in the Chiropractic Adjustment:** Serious complications to chiropractic treatment are rare. However, these may include fractures, disc injuries, dislocations, muscle strain, ligamentous sprain, and nerve injuries. Some patients may feel some stiffness or soreness following the first few days of treatment, which is considered normal.

**The probability of serious complications occurring:** Fractures, especially of the ribs, are rare occurrences and generally result from some underlying weakness of the bone such as osteoporosis. If you suffer from osteoporosis, please tell you doctor and care steps will be taken to adjust your spine. Stroke has been the subject of much study and debate within the health professions. Manipulation of the neck has been associated with other injuries to the arteries in the neck leading to a stroke in rare instances. Studies have estimated this occurrence rate to be between 1 in 1 million to 1 in 3 million adjustments. To put this in perspective, your chances of being hit by lighting are reported to be 1 in 3 million. We employ tests in our examination which are designed to identify possible risk factors for stroke and we combine this with your medical history and our clinical skills to determine if you are a candidate for cervical manipulation. Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem and rarely surgery may become necessary to treat a disc injury. If necessary, we will refer you to a neurosurgeon or for an MRI exam. These problems are also rare with no reliable statistics to quantify their probability.

**Ancillary treatments:** In addition to chiropractic adjustments (manipulation of the joints), I intend to use the following treatments as needed to treat you condition:

- *Ice or Heath Packs: these may be used in the office or recommended for home use. Both may, in rare cases, irritate or burn the skin.
- *Myofascial release, Active Release Technique, and Trigger Point Therapy, which may, in rare cases, causes local bruising and soreness.
- *Electrical Stimulation: this therapy consists of a mild electrical current which helps relax tight muscles, blocks pain, reduces swelling, and facilitates healing. There are no known side-effects other than discomfort if the settings are too high. At any time, if any of these procedures are uncomfortable, you are to notify the doctor and/ or staff immediately and the procedure will be modified or discontinued.
- *Therapeutic and rehabilitative exercises, Active Release Technique, Neuromuscular Re-education, and Post Isometric Relaxation (PIR): these may be used to re-educate your muscles to restore normal functions and muscular balance. Every precaution is used to prevent injury. Injuries are rare and are usually from the patient "over doing it" or over stretching. Please follow your doctor's recommendations carefully.

Initial: _____ Date:_____

**Alternative Medical Treatments Risks are:**

- *Self-administered over the counter NSAIDS may cause gastro-intestinal problems and bleeding of liver and kidney disease. i.e.; Aspirin, Ibuprophen, Aleve, etc.

- *Prescription muscle relaxants and pain killers can produce undesirable side-effects and addictions. They can also make you drowsy and impair your motor skills.

- *Hospitalization and bed rest has the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% per day. It is very expensive, and research has shown bed rest has no benefit in helping back pain patients. In fact, it may make your condition worse.

- *Back or neck surgery poses many risk such as: infections, allergic reactions, disfiguring scars, severe loss of blood; loss of function of any limb, organ paralysis, paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder, bowel or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post-operative bleeding; unstable spine requiring fusion; and infection.

- *Injections of pain medications: The risks inherent in using injections or surgery included adverse reactions to anesthesia or the injected medication, iatrogenic (caused by a doctor) problems, hospitalization and possible convalescent time.

**The Risks and Dangers of Remaining Untreated:** Remaining untreated allows the formation of adhesions and reduced joint motion, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage and muscle weakness may progress if your spinal problem goes untreated.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION**

I have read, or have had read to me, the above information. I have had an opportunity to ask my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I seek treatment in this office. Having considered the nature and risks of chiropractic care, I hereby give my consent to be treated.

| Patient's Name (Printed) | Patient's Signature | Date |
|---|---|---|

***If you are a minor, or if you are being represented by another party:**

| Name of Parent or Guardian (printed) | Signature of Parent or Guardian | Date |
|---|---|---|

**Witness:**

| Name of Witness (Printed) | Signature of Witness | Date |
|---|---|---|

Patient Exam Form

Date:

Health Questionnaire

Patients Name:_____DOB:____/____/____ Chart:_____

What is your height?_____ft.____in. How much do you weigh? ____lbs.

**Circle all that apply: *(If none apply circle normal)***

**General Review of Systems:**
Normal Fatigue Weakness Fever/ Chills Weight change Night sweats
Depression Anxiety Phobias Mood Swings Memory Loss or Impairment

**Neurological:**
Normal Headache Dizziness Fainting Convulsions Other_____

**Head & ENT:**
Normal Vision Trouble Eye pain Eye discharge Ringing in the Ears Ear pain
Ear discharge Hearing trouble Nose pain Nose Discharge Nose bleeding Absence of smell
Mouth sores Mouth Bleeding Absence of Taste Abnormal Taste Other_____

**Cardiovascular:**
Normal Cough Wheezing Difficulty Breathing Swollen Extremities Blue Extremities
Murmur Chest Pain Palpitations Other_____

**Breast/ Chest:**
Normal Lumps in Breast/ Chest Redness/ Itching Pain Discharge Dimpling
Other_____

**Gastrointestinal:**
Normal Decreased Appetite Increased Appetite Abdominal Pain Vomiting
Diarrhea Constipation Other_____

**Genitourinary:**
Normal Inability to hold Urine Painful Urination Frequent Urination
Irregular Menstruation Painful Menstruation Abnormal Vaginal Bleeding
Impotence Sterility Other_____

**Endocrine:**
Normal Rash Redness Itching Eczema Nail Changes Hair Changes
Other_____

**Glandular:**
Normal Heat/Cold Intolerance Sugar in Urine Goiter Tremor Other_____

**Allergy/Sensitivity**:
Medication Animal Food Seasonal None Other_____

**Surgery:**
Neck Surgery Heart Surgery Low back surgery None Other _____

**Medications:**
Anti-inflammatory Muscle Relaxants Tranquilizers Pain Medication/Analgesic Birth Control Pills
High Blood Pressure Thyroid Medication Diabetes Medication None reported Other _____

Patient Exam Form

Date:

**Illnesses:**
Allergies Arthritis Asthma Bone Fracture Cancer Diabetes Dislocated Joints
Epilepsy Hay Fever Heart Trouble High Blood Pressure HIV/AIDS Low Blood Pressure
Kidney Trouble Mental/Emotional Difficulty Multiple Sclerosis Polio Prostate Trouble
Rheumatic Fever Scoliosis Serious Injury Sexually Transmitted Disease Sinus Trouble
Spinal Disease Thyroid Trouble Tuberculosis Ulcer None Other:_____

**Major Injuries:**
Car Collision Domestic or family violence Major Surgery Serious injury Sexual or physical abuse
None Other:_____

**Employment Status:**
Employed Unemployed Student Retired

**Social Habits:**
Smoking/ E- cigarettes: How often? _____ How much?_____ None Drinking: How often? _____
How much?_____ None Recreational Drugs: How often? _____ How much?_____ None

**Exercise Habits:** Strenuous Moderate Light None

**Circle all that apply**: Aerobics Bicycling Hiking Jogging Skiing Swimming
Volleyball Working out/ Weight lifting Basketball Football Ice hockey/ Inline skating Martial arts
Soccer Tennis Walking Yoga Baseball/ Softball Golf Other_____

**Family History:**
Back Problems Bad Posture Cancer Diabetes Disc Problems Headaches Heart Trouble
High Blood Pressure Joint Problems Multiple Sclerosis Neck Problems Osteoporosis Stroke
Pinched Nerve Scoliosis None Other:_____

Please list all prescription medications you are currently taking:_____

Please list all supplements you are currently taking:_____

Please list all surgical procedures you have had:_____

Notes:_____

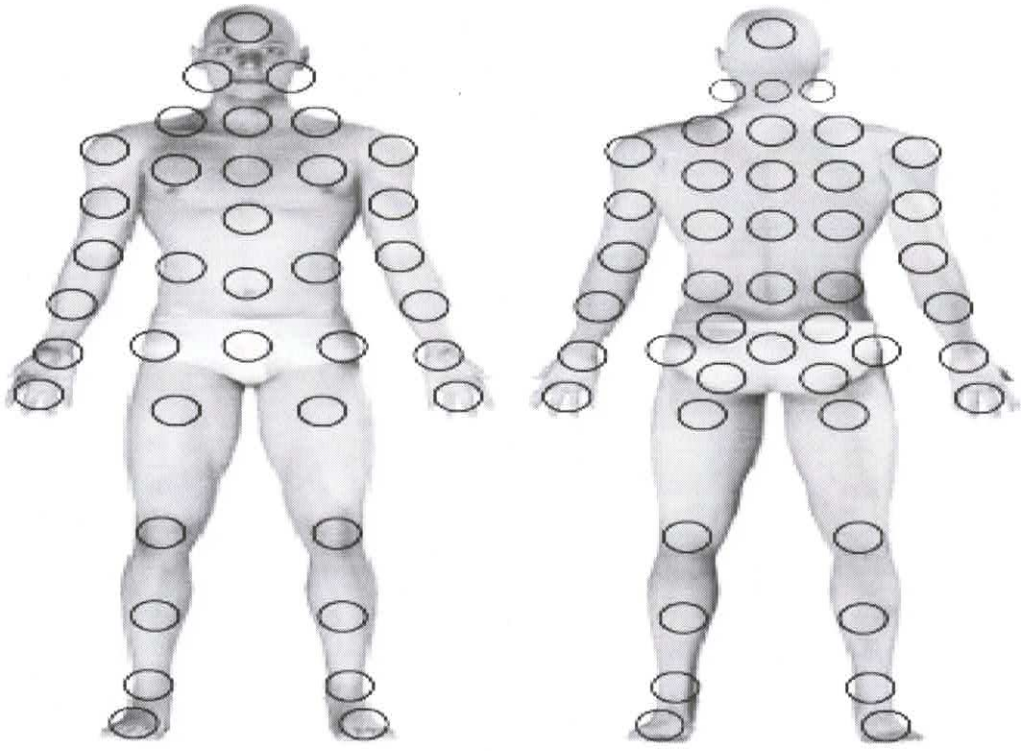
Patient Exam Form

Date:

Patients Name:_____DOB:____/____/____ Chart:_____

**Chief Complaint:**

**Please choose the location(s) of your problem(s):**



When did symptoms start? : _____

Where did your symptoms occur?( Ex: Home, Gym) : _____

On a scale of 1 to 10 rate your pain at its worst: _____

How did symptoms occur? (Ex: Lifting, bending, walking) _____

How often does pain occur?_____

What makes the pain better?: _____

What makes the pain worse?: _____

Is there anything else you think the doctor should know? _____

Notes:_____

_____

_____