New Patient Paperwork

Please print

Name:_____ **Date**:_____

Cell Phone: _____ **Email**: _____

Address:_____

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

Date of Birth:_____ **Age**:_____ ◯ Male ◯ Female

Marital Status:_____ **Name of Spouse**:_____ **Number of Children**:_____

Occupation:_____ **Employed by**:_____

How did you hear about us? (Check all that apply): ◯ Google ◯ Facebook ◯ Instagram

◯ Other: _____ ◯ Patient: _____ ◯ Doctor Referral: _____

Health Goals

What are your top three health goals?

1.) _____

2.) _____

3.) _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition ◯ Overall wellness + prevention ◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No

What was their specialty? ◯ Pain Relief ◯ Nutritional ◯ Subluxation-based ◯ Other:_____

Health Concerns

What are your primary health concerns?

_____

_____

Please describe when your issues first began and how they've progressed since:

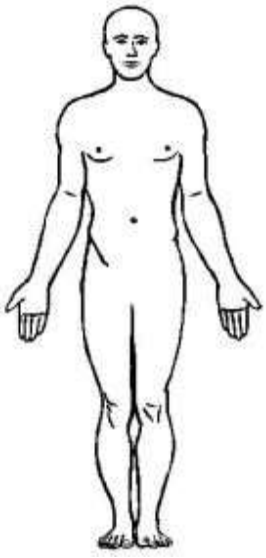
_____

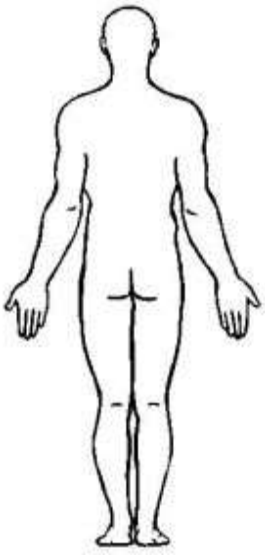
What makes things better?

_____

What makes things worse?

_____





Place an "X" on any areas of current pain. How would you describe this pain? _____

_____

_____

On a scale of 1- 10 (1 being the mildest and 10 being most severe), please you rate each area of pain.

_____

_____

_____

Please circle any issues you are currently experiencing:

Neck Pain	Scoliosis	Constipation	Headaches
Shoulder Pain	Cancer	Diarrhea	Autism
Mid Back Pain	Stroke	Gastric Reflux	Asthma
Low Back Pain	Heart Disease	Throat Issues	TMJ
Sciatica	Diabetes	Food Allergies	Ear Infections
Hip Pain	Thyroid Problems	Chronic Fatigue	Seasonal Allergies
Leg Pain	Stomach Disorders	Anxiety	Chronic Sinus Infections
Arm Numbness	Bladder Problems	Depression	Menstrual Issues
Hand Numbness	Liver Disease	ADD/ADHD	Other:
Leg Numbness	Autoimmune Disorders	Fibromyalgia	
Foot Numbness	Seizures/Epilepsy	Dizziness	

List all current medications:_____

List surgeries and dates: _____

List any trauma or car crashes:_____

Women: Any chance you could be pregnant? ◯ Yes ◯ No

Family History

Any family health history information you would like to provide (e.g., stroke, cancer, heart disease):_____

_____

Patient Signature:_____ Date: _____

I agree to adopt responsibility for any/all charges created by my Chiropractic care and give consent to be examined and/or treated by the Doctors and staff of Revolution Chiropractic.

Consent to Treat

Just as with all forms of health care, Chiropractic, while offering numerous benefits, may also afford some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely fractures. One of the rarest complications, occurring at a rate between one occurrence per one million to one per two million cervical spine adjustments may be a vertebral injury that could lead to a stroke.

The risk of injury or complication from Chiropractic treatment is substantially lower than that associated with many other treatments or procedures performed for the same symptoms/conditions.

Prior to receiving Chiropractic care an examination and consultation will be completed to further assess if Chiropractic care is the right choice and the quantity necessary for your condition.

I have read the aforementioned statements and hereby give consent to participate in the treatment(s) offered or recommended including osseous adjustments. If at any time I have further questions or decide to discontinue my care, I understand I have that right and it is my responsibility to inform my Doctor.

_____	_____	_____
Print	Patient Signature	Date

IF PATIENT IS A MINOR/CHILD, PARENT/GUARDIAN MUST SIGN BELOW

_____	_____	_____
Print	Patient Signature	Date
_____	_____	_____
Relationship to minor	Witness Signature (Office Staff)	Date

Late Fee Agreement

Effective January 1st 2020 there will be a $25 fee (late fee) for payments received 5 days + after payment is due. By signing below, you are agreeing to the above terms and conditions.

Patient Signature:_____ Date:_____

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Jason Kramer LLC DBA Revolution Chiropractic, Jason Kramer, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Patient Signature:_____ Date:_____

Terms of Acceptance

When working toward the same objective(s), the patient and Doctor are able to achieve their goals much more efficiently. The goal of Chiropractic and method of achieving such goals may be accomplished when there is a clear understanding of those goals/objectives.

ADJUSTMENT: The SPECIFIC application of forces used to facilitate the body's correction of nerve interference.

HEALTH: A state of optimal physical, mental, and social well-being; not merely the absence of sickness or disease.

VERTEBRAL SUBLUXATION: A portion of one or more areas of the central nervous system at a vertebral level in the spinal column reducing the flow of information and possibly the size of the openings between the vertebrae through which nerves run, causing alteration of nerve function and interference to the flow of mental impulses, resulting in a lessening of the body's Innate ability to express its maximum health potential.

Revolution Chiropractic makes no claims other than correcting vertebral subluxation and the components thereof. If other treatments/therapies or diagnoses are necessary, a referral will be made to a specialist best suited for the individual patient and condition.

I, _____ have read, fully understand, and accept the statements above. I accept Chiropractic care on the basis that my questions concerning treatments and methods have been satisfied.

Patient Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from 3rd party payers
3) Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more detailed description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient Signature:_____ Date:_____