New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name Last Name Date Email*

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements.

Language: ○ English ○ Spanish ○ Other

Race/Ethnicity: ○ White ○ Black/African American ○ Hispanic ○ Asian ○ Other ○ Decline to Answer

Contact Information

Address City State Zip

Telephone (home) (work) Referred By Birthdate age

Social Security # # Children Occupation Employer

Marital Status Spouses Name Spouse's Occupation

Current Complaints:

Nature of Injury: ○ Automobile ○ Work ○ Other

Please describe:

Date of Injury Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other Doctors seen for this condition/injury

Have you ever been under Chiropractic Care? ○ No ○ Yes

Do you experience pain every day? ○ No ○ Yes Do your symptoms interfere with daily life? ○ No ○ Yes

Does pain wake you up at night? ○ No ○ Yes Do you wear orthotics? ○ No ○ Yes

What activities aggravate your symptoms?

Do you have Clicking in your neck and/or back ○ No ○ Yes Is your condition getting worse? ○ No ○ Yes

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam Is there any chance that you are pregnant? ○ No ○ Yes

Have you had x-rays or MRI's taken? ○ No ○ Yes If yes, when?

Do you smoke? ○ Never ○ Former Smoker ○ Current/Everyday Smoker ○ Current Some Day(s) Smoker

Height Weight Blood Pressure from most recent exam

Medications: What medications are you currently taking? Please include Name, Dosage, Frequency and Managing/Prescribing Doctor

Allergies: ○ Medication ○ Food ○ Environmental ○ None If yes, plist list the type of allergy

Have you ever been diagnosed with hypertension? ○ No ○ Yes If yes, who is managing Doctor?

Have you ever been diagnosed with diabetes? ○ No ○ Yes If yes, who is managing Doctor?

Have you ever had any work related injuries? ○ No ○ Yes

Have you ever been in any motor vehicle accidents (>5 mph)? ○ No ○ Yes

Do you sleep on ○ your side ○ your back ○ your stomach What type of Mattress do you have?

Family History	Father's Side	Mother's Side
Heart disease	○ Yes	○ Yes
Cancer	○ Yes	○ Yes
Diabetes	○ Yes	○ Yes

Have you ever suffered from or experienced any of the following?		
○ Alcoholism	○ Numbness in Toes	○ Loss of Balance
○ Headaches	○ Numbness in Fingers	○ Ringing in Ears
○ Neck Pain	○ Fatigue	○ Fainting
○ Sleeping Problems	○ Depression	○ Loss of Smell
○ Back Pain	○ Loss of Memory	○ Loss of Taste
○ Nervousness	○ Constipation	○ Cold Feet
○ Chest Pain	○ Shortness of Breath	○ Cold Hands
○ Pins/Needles in Legs	○ Dizziness	○ Irritability
○ Pins/Needles in Arms	○ Stiff Neck	○ Weight Issues

☐ **I choose to decline receipt of my clinical summary after every visit** (These summaries are often blank as a result of the nature and frequency of Chiropractic care)

Patient Signature: _____

PATIENT HIPPA AWARENESS

With my permission, Touch of Life Chiropractic East, P.C. (TLCEAST), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to TLC East Notice of Privacy Practices for a more complete description of such uses and disclosures. (available to view by request)

I have the right to review the Notice of Privacy Practices prior to signing this consent. TLC East reserves the right to revise its Notice of Private Practices at any time. A revised edition may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of TLC East may call my home or other designated locations and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including x-rays, MRI's and other diagnostic testing.

With my permission, TLC East, may mail (or email) to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal or confidential.

I have the right to restrict how, TLC East, uses or disclose my PHI to carry out TPO. I must provide in writing any restrictions. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing TLC East, to use and disclose my PHI for TPO as noted above. No information regarding your care will be used without your consent.

You have the right, by request to see the offices complete HIPPA manual.

I may revoke me consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patients Name: _____ Date:_____

Signature of Patient/Guardian: _____

Touch of Life Chiropractic East, P.C.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care,
it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interferences to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of gentle forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

_____ has read and fully understand the above statements.
print name

Please address any questions or concerns with the Doctor, prior to commencing any treatment.

By signing this, I hereby accept Chiropractic Care in this office.

_____ _____
signature date

Name:_____ Date of Birth: _____ SS# _____

Email: _____ FREE Monthly Wellness Newsletter Y N

INSURANCE INFORMATION

Insurance Company _____ Policy# _____

Insured's Name _____ Patient relationship to the insured ☐ Self ☐ Spouse ☐ Child

Insurance Company phone number _____

Secondary Policy ☐ Yes ☐ No If Yes, name of Secondary _____

Secondary Policy # _____

Secondary Company phone number _____

IF MOTOR VEHICLE RELATED PLEASE ANSWER THE FOLLOWING

Insurance Company: _____ Policy Holder of Vehicle: _____

Claim # (If Known) _____ Policy # (If Known): _____

Date of Accident: _____ Attorney (If Known): _____

ASSIGNMENT OF BENEFITS (EVERYONE MUST COMPLETE)

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Touch of Life Chiropractic and its Doctors, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance, except in instances were No-Fault or Workers' Compensation fee schedules apply. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature of responsible party: _____ Date: _____

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to Touch of Life Chiropractic or its Doctors, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of responsible party: _____ Date: _____