Date: ____________

New Patient Questionnaire

Full Name: ________________________ **Birthday:** ____________ **Age:** ______

Address: ________________________ **City:** ____________ **State:** _____ **Zip:** ________

(Home Phone)________________ **(Work Phone)**________________ **(Cell Phone)**________________

Email Address: ________________________ **Social Security Number:** ________________

Occupation:________________________ **Employer:** ________________________

Sex: M F **Marital Status:** S M D W

Spouse's Name: ________________________ **Occupation:** ________________________

Children's Name & Ages: ____

Emergency Contact Name: ________________ **Phone Number:** ____________ **Relationship:** ____________

Favorite Hobbies & Interests: ____

How were you referred to our office? ________________________

Do you have Insurance? ( ) No ( ) Yes

Do you have Medicare? ( ) No ( ) Yes

Name of Insurance Company: ________________________

Policy Member Number:________________________ **Group Number:**________________

Policy's Holder's Full Name (If different from above)**:** ________________________ **DOB:**________________

Your Relationship to Policy Holder: ________________

Reason For This Visit:

Define the purpose of this visit:

____

Is the purpose of this appointment related to:

( ) Job ( ) Sports ( ) Auto ( ) Fall ( ) Chronic Discomfort ( ) Home Injury ( ) Wellness ( ) other________________

If Job related, have you made a report of your accident to your employer? ( ) Yes ( ) No

When did this condition begin? ____________ has this condition: ( ) gotten worse ( ) Stayed constant ( ) comes & goes

Does this condition interfere with: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Other Activities

Explain: ____

Describe the pain…sharp, dull, throbbing, burning, etc.________________________________

Has this condition occurred before? ( ) Yes ( ) No Explain: ________________________________

On a scale of 1-10 (1 least, 10 most), please rate the severity of your symptoms: ___/10.

Have you seen other doctors for this condition? ( ) Yes ( ) No

Dr.'s Name(s) ________________________

Type of Treatment ________________________

Results ________________________

Have you been to a Chiropractor before? ( ) Yes ( ) No If yes, approximate date of last visit? ________________

Medications I Now Take:
( ) Nerve Pills
( ) Pain Killers (including aspirin)
( ) Muscle Relaxers
( ) Insulin
( ) Stimulants
( ) Blood thinners
( ) Tranquilizers ( )________________
( )________________ ( )________________

Health Habits:

Do you smoke?	( ) No ( )Yes ___Packs/day
Do you drink coffee?	( ) No ( )Yes ___Cups/day
Do you drink alcohol?	( ) No ( )Yes ___Drinks/day
Do you exercise?	( ) No ( ) Moderate ( ) Daily
Do you wear?	( ) Heal Lifts ( ) Sole Lifts ( ) Inner Soles ( ) Arch Supports
Do you take Supplements?	( ) No ( )Yes

Past Injuries can affect present health. (*Please check all that apply*)

( ) Falls/Accidents
( ) Broken Bones
( ) Uses Cane/Walker
( ) Surgery(s) please explain:
( ) Head Injuries
( ) Dislocations
( ) Extensive Dental Work
( ) Fights
( ) Spinal Tap
( ) Sports Injuries
( ) Knocked Unconscious
( ) Other____________________
____

Date of last visit with physician? ________________ Name of M.D.: ____
Address: ____ Phone: ________________________

HEALTH CONDITIONS:
Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and being accepted for care.

( ) Severe or Frequent headaches
( ) Sinus Problems
( ) Dizziness
( ) Loss of Sleep
( ) Pain between the Shoulders
( ) Frequent Neck Pain
( ) Numbness or Pain in Arms/Legs/Hands
( ) Lower Back Problems
( ) Digestive Problems
( ) Ulcers/Colitis
( ) Heart Attack/Stroke
( ) Congenital Heart Defect
( ) Heart Surgery/Pacemaker
( ) Heart Murmur
( ) High/Low Blood Pressure
( ) Thyroid Problems
( ) Allergies, To what?____________________
( ) Fibromyalgia
( ) Asthma
( ) Arthritis
( ) Alcohol/Drug Abuse
( ) Venereal Disease
( ) HIV/AIDS
( ) Diabetes, Type1 or 2
( ) Tuberculosis
( ) Shingles
( ) Kidney Problems
( ) Hepatitis
( ) Cancer
( ) Chemotherapy
( ) Anemia
( ) Rheumatic Fever
( ) Psychiatric Problems
( ) Depression
( ) Osteoporosis
( ) Jaw Pain
( ) Others Not Listed above ______________________________________ Please tell us.

For Women:

Are you Pregnant?	( ) yes ( ) no
Are you nursing?	( ) yes ( ) no
Are you taking Birth control?	( ) yes ( ) no
Do you experience painful periods?	( ) yes ( ) no
Do you have irregular cycles?	( ) yes ( ) no
Do you have breast implants?	( ) yes ( ) no

The above is accurate to the best of my knowledge.

_________________________________ _________________________
Signature of patient (or guardian) Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operation, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. The patient's written request consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, our office has the right to refuse to give care.

The HIPAA compliance officer for Carlsbad Chiropractic & Integrative Wellness is Dr. Jason Higgins.

Patient Health Information Consent Form Acknowledgement of Receipt

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Print Name: ____

Patient Signature: ____________________________________ Date:__________________

Carlsbad Chiropractic
& Integrative Wellness

CANCELLATION POLICY

Our goal is to provide quality individualized chiropractic care in a timely manner. "No shows" and late cancellations inconvenience those individuals who need access to care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for those in need of care.

Carlsbad Chiropractic & Integrative Wellness is committed to offering the best service to everyone who needs our services and we commit the best resources available to your appointment. Therefore, we require a ***minimum of 24-hour Cancellation Notice for massages and at least a 2-hour Cancellation Notice for chiropractic appointments.***

Please Initial

☐ **For massage** – "No show"/late cancellations will be billed for half of the price of the first appointment, then 100% of the appointment for any subsequent missed appointments.

Please Initial

☐ **For chiropractic** – "No shows"/late cancellations will be billed $30. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

As always we will try our best to give you a courtesy reminder about your appointment via email or text, however, it is your responsibility to remember your appointment once you have made it.

Patient's Name: ___________________________ Signature of Patient: ____

Date Signed: ___________________________

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