PATIENT INFORMATION

Patient Title: (Check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.
First Name_____ Middle Name_____ Nick Name_____
Last Name_____ Suffix_____ Previous Name_____
Address_____ City _____ State_____ Zip Code_____
Primary Phone_____ Secondary Phone_____ Cell Carrier (for text reminders)_____
Email (by providing my email address, I authorize my provider to contact me)_____
Contact Method: (Check one) ☐ Primary phone ☐ Secondary phone ☐ Email

Place of Employment_____ Work phone_____
Social Security Number_____-_____-_____
Referred by: (Check one) ☐ Patient ☐ Physician ☐ Internet ☐Other Name of person_____
Date of Birth: _____ / _____ / _____ Age_____ Gender: ☐ Male ☐ Female
Marital Status: (Check one) ☐ Single ☐ Married ☐ Other
Spouse Name & Phone number_____

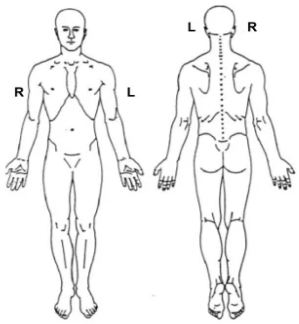
Emergency Contact: Name_____ Relationship_____ Phone Number:_____

Insurance_____ Insured's Name_____
Insured's Date of Birth _____ / _____ / _____ Insured's Place of Employment_____

PATIENT CONDITION

Reason(s) for visit_____
Is this condition due to an accident ☐No ☐Yes: (circle one) Auto Work Home Date of occurrence:_____
If this is a work related injury, will you be opening a workman's compensation case? ☐Yes ☐No
When did your symptoms appear?_____
Is it constant pain? ☐Yes ☐No Does the pain come and go? ☐Yes ☐No
How often do you have this problem?_____ How long does the pain last?_____
Does the pain radiate? ☐Yes ☐No If Yes, please explain:_____
Does the pain interfere with: ☐Work ☐Sleep ☐Daily routine ☐Recreation
Activities or movements that are difficult to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Mark an "X" on the picture where you continue to have pain, numbness, or tingling:



Circle your pain on the scale below of 0-10:
At rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain
With activity: No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain

What time of day is your current pain/problem worse?
☐Morning ☐Late in the day ☐Middle of the night ☐As the day progresses ☐N/A
Current pain/problem can be described as: (Check all that apply)
☐Electric ☐Sharp ☐Stabbing ☐Knife-like ☐Piercing ☐Shooting ☐Achy
☐Griping ☐Heavy ☐Cramp-like ☐Burning ☐Deep ☐Superficial ☐Stiffness (AM, PM, or both?)
☐Spasms ☐Tearing ☐N/A
What treatment have you already received for this condition?
☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Care ☐None

Name of other doctor(s)/provider(s) who have treated you for this condition and how: _____

PERSONAL HEALTH HISTORY & REVIEW

How many hours of sleep are you getting per night? ☐Less than 5 hours ☐6-8 hours ☐8-10 hours ☐10+ hours
How would you rate your sleep on the following scale? Wake up fully rested 1 2 3 4 5 6 7 8 9 10 No/Poor sleep
How many days a week do you exercise for 30 minutes or more? ☐ 0 ☐ 1-2 ☐ 3-4 ☐5-6 ☐ 7
How would you rate your intensity of your exercise? High Intensity 1 2 3 4 5 6 7 8 9 10 No Exercise
How would you rate your physical stress level? No Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed
How would you rate your emotional stress level? No Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed
List your major stressors: _____
What are your health goals?_____
In addition, talk to your provider about other areas which may be affecting your health, such as financial worries, social support, and alcohol/tobacco/drug use.

Are you currently under the care of any Healthcare Provider or Physician? ☐Yes ☐No
If yes, for what conditions?_____
Provider(s) Name(s):_____
_____

Has your doctor diagnosed you with Hypertension recently? ☐Yes ☐No Last blood pressure: _____ / _____
Has your doctor diagnosed you with Diabetes recently? ☐Yes ☐No
If yes, was your blood lab work test for Hemoglobin A1c > 9.0%? ☐Yes ☐No ☐Unknown
If yes, other comments regarding diabetes:_____
Have you had an x-ray or CT scan or MRI scan of your low back (lumbar spine) in the past 28 days? ☐Yes ☐No

Do you wear any of the following? ☐Heel Lifts ☐Innersoles ☐Arch Supports ☐Orthotics ☐Other_____
For how long? _____ Were they prescribed by a doctor? ☐Yes_____ ☐No
Have you seen a chiropractor in the past? ☐Yes ☐No Date of last visit: _____/____/_____
Were you satisfied with your care? ☐Yes ☐No Why? _____

Dates of last:

Chiropractic Exam		Prostate / PSA	
Cholesterol		Mammogram	
MRI scan		Pap Smear	
CT scan		Colonoscopy	
Spine x-ray		Stool check for blood	
Bone density scan			

Childhood Illnesses:

☐ ADD
☐ Atopic dermatitis
☐ Allergies / Hay fever
☐ Anemia
☐ Asthma
☐ Bed wetting
☐ Cerebral palsy
☐ Chicken Pox
☐ COVID
☐ Crohn's / Colitis
☐ Depression
☐ Diabetes
☐ Ear infections
☐ Fetal drug exposure
☐ Headaches
☐ Hepatitis
☐ HIV
☐ Measles
☐ Mumps
☐ Psoriasis
☐ Rash
☐ Scoliosis
☐ Seizures
☐ Sickle Cell
☐ Spina Bifida
☐ Other:

Immunizations:

☐ All recommended vaccines
☐ Adenovirus
☐ DTaP(diphtheria,tetanus,pertussis)
☐ Hepatitis B
☐ Influenza
☐ MMR (measles, mumps, rubella)
☐ Rotavirus
☐ Varivax (chicken pox)
☐ Not vaccinated
☐ COVID _____
☐ Haemophilus B
☐ Gardasil
☐ IPV (polio)
☐ Pneumoccocal
☐ Tetanus
☐ Other:_____

Adult Illnesses:

☐ ADD	☐ Crohn's / Colitis	☐ Hepatitis	☐ Pneumonia
☐ Allergies / Hay fever	☐ CRPS (RSD)	☐ HIV	☐ Psoriasis
☐ Alzheimer's	☐ CVA (stroke)	☐ High blood pressure	☐ Psychiatric condition
☐ Arthritis	☐ Cystic Kidney disease	☐ Influenza pneumonia	☐ Scoliosis
☐ Asthma	☐ Depression	☐ Liver disease	☐ Seizures
☐ Atopic dermatitis/eczema	☐ Diabetes	☐ Lung disease	☐ Shingles
☐ Cancer	☐ Emphysema	☐ Lupus Erythema	☐ STDs/STIs
☐ Cerebral palsy	☐ Eye problems	☐ Multiple Sclerosis	☐ Suicide attempt(s)
☐ Chicken Pox	☐ Fibromyalgia	☐ Parkinson disease	☐ Thyroid problems
☐ COVID	☐ Heart disease	☐ Pleural effusion, unspecified	☐ Vertigo

☐ Other: _____

Injuries (list date next to injury):

☐ back injury	☐ fracture	☐ laceration (severe)
☐ broken bones	☐ head injury	☐ motor vehicle accident
☐ disability (ies)	☐ industrial accident	☐ soft tissue injury
☐ fall (severe)	☐ joint injury	☐ other:_____

Surgeries:

Date	Procedure & Description	
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient
		Inpatient / Outpatient

Please check the appropriate response. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does the pain you have improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?
☐	☐	☐	Prolonged use of corticosteroids (such as with organ transplant)?
☐	☐	☐	IV drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication and/or conditions?
☐	☐	☐	Are you currently or have you used blood thinners?
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person > 50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Acute onset urinary tract retention or overflow incontinence (wet underwear)?
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)?
☐	☐	☐	Saddle anesthesia (numbness in the groin region)?
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)?

REVIEW OF SYSTEMS

Please indicate if you have any of the following by checking the box.

Cardiovascular	☐ none ☐ high blood pressure ☐ low blood pressure ☐ heart problem ☐ heart murmur ☐ claudication (leg pain and ache) ☐ orthopnea (difficulty breathing laying down) ☐ palpitations ☐ ulcers ☐ shortness of breath with exertion ☐ paroxysmal nocturnal dyspnea ☐ varicose veins
Constitutional	☐ none ☐ daytime drowsiness ☐ fever ☐ night sweats ☐ chills ☐ fatigue ☐ weight gain/loss ☐ loss of appetite
Ears, Nose, & Throat	☐ none ☐ fainting ☐ history of head injury ☐ runny nose ☐ nosebleeds ☐ dizziness ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infection ☐ ear pain ☐ ear discharge ☐ headaches ☐ hearing loss ☐ nasal congestion
Eyes/Vision	☐ none ☐ cataracts ☐ double vision ☐ eye problems ☐ itching ☐ photophobia ☐ blindness ☐ blind spots ☐ tearing ☐ wear contacts/glasses
Female	☐ none/NA ☐ birth control ☐ breast lump/pain ☐ burning urination ☐ frequent urination ☐ abnormal vaginal bleeding ☐ hormone therapy ☐ irregular menstruation ☐ vaginal discharge ☐ cramps ☐ urine retention/incontinence I … ☐ am currently pregnant ☐ am NOT currently pregnant I … ☐ currently have menses ☐ DO NOT currently have menses My menses … ☐ are regular ☐ are NOT regular Age of first menses: _____ Age when menopause began: _____ Date of last menstrual period: _____/_____/_____ If you have been pregnant in the past, please fill in the appropriate information below. _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies _____ Number of c-sections _____ Number of vaginal deliveries _____ Number of miscarriages _____ Number of terminated pregnancies
Gastrointestinal	☐ none ☐ belching ☐ black/tarry stool ☐ constipation ☐ diarrhea ☐ difficulty swallowing ☐ abdominal pain ☐ heartburn ☐ hemorrhoids ☐ indigestion ☐ jaundice ☐ ulcers ☐ abnormal stool ☐ rectal bleeding ☐ loss of bowel control
Hematologic	☐ none ☐ bleeding ☐ blood transfusion ☐ fatigue ☐ ☐ ☐ anemia ☐ blood clotting ☐ bruising easily ☐ lymph node swelling
Male	☐ none/NA ☐ burning urination ☐ frequent urination ☐ prostate problems ☐ ED (erectile dysfunction) ☐ hesitancy/dribbling ☐ urine retention/incontinence
Nervous System	☐ none ☐ headache ☐ limb weakness ☐ loss of consciousness ☐ loss of memory ☐ dizziness ☐ numbness ☐ seizures ☐ sleep disturbances ☐ slurred speech ☐ stroke ☐ facial weakness ☐ stress ☐ unsteadiness of gait/loss of balance
Psychological	☐ none ☐ bipolar disorder ☐ depression ☐ confusion ☐ convulsions ☐ insomnia ☐ anxiety ☐ behavioral changes ☐ loss or change of appetite ☐ memory loss ☐ mood change
Respiratory	☐ none ☐ cough ☐shortness of breath ☐ wheezing ☐ asthma ☐ coughing up blood ☐ sputum production
Sexual Health	Do you have any concerns about your sexual health? ☐ yes ☐ no Are you or have you ever been a victim of domestic or sexual abuse? ☐ yes ☐ no
Skin	☐ none ☐ change in nail texture ☐ change in skin color ☐ hair loss ☐ hives ☐ itching ☐ history of skin disorders ☐ numbness ☐ rash ☐ skin lesions/ulcers ☐ varicosities
Teeth/Oral	☐ metal amalgam fillings ☐ root canal(s) ☐ wisdom teeth removed ☐ cavitations ☐ post ☐ implant(s) ☐ bridge ☐orthodontic braces ☐ TMJ issues

ALLERGIES

Are you allergic to any medication(s)? ☐Yes ☐No
If yes, which medications?
_____

Are you allergic to any of the following?
☐Bee stings ☐Latex ☐Peanuts ☐Shellfish
☐Dairy ☐Mold ☐Pollen ☐Wheat ☐Eggs
☐Nuts ☐Gluten ☐Other_____

SMOKING HISTORY

Do you currently smoke tobacco of any kind?
☐Yes ☐Former Smoker ☐Never been a smoker
Do you currently vape? ☐Yes ☐No ☐Sometimes
If yes, how often do you smoke?
☐Current every day smoker
☐Current sometimes smoker
If yes, what is your level of interest in quitting smoking?
0 1 2 3 4 5 6 7 8 9 10
No interest Very interested

MEDICATIONS

List current medication, including frequency and dosage. Please include over-the-counter medications.
If there are no current medications, check here ☐
(Patient may bring a list of medications and attach it to this form, if needed)

MEDICATION NAME	QUANTITY / DOSAGE	FREQUENCY	START DATE

SOCIAL HISTORY

Work Activity: What is your job description? _____
What work do you do most of the day at work? ☐Sitting ☐Standing ☐Light labor ☐Heavy labor ☐Other
What job did you do most of your life? _____
How would you describe the physical stress level at work? _____
Level of education completed: ☐High school ☐College ☐Trade school

Nutrition / Diet:

Blood type? ☐O ☐A ☐AB ☐B ☐Do not know
Rate your appetite (circle one): Normal appetite 1 2 3 4 5 6 7 8 9 10 Eat nothing
Do you drink water? ☐Yes ☐No Filtered water? ☐Yes ☐No
Alcohol use: Now? ☐Yes ☐No Amount/Weekly_____
In the past? ☐Yes ☐No Amount/Weekly_____
How many coffee caffeine drinks do you drink a day? Cups _____ None ☐
How many soda caffeine drinks do you drink a day? Cups _____ None ☐

List current vitamins/minerals/herbs: (Please include quantity/dosage & frequency.)

_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Relation	Age (now or at death)			Serious illness/Cause of death
Father		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Paternal grandfather		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Paternal grandmother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Mother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Maternal grandfather		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Maternal grandmother		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Brother(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Sister(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Son(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	
Daughter(s)		☐ alive ☐ deceased	☐ no significant disease ☐ has/had _____	

All the answers I have given are correct and to the best of my knowledge. I agree to continue my care at this time.

_____

Patient Signature Date

_____

Signature of Parent or Legal Guardian Relationship

Van Engen Chiropractic and Health Center & New Life Chiropractic

CONSENT for Purposes of Treatment, Payment and Healthcare Questionnaire

I, _____ (Name of Individual) consent to Van Engen Chiropractic and Health Center's, including New Life Chiropractic ("The Practices") 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 Practices general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, clinical education, 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 my 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 healthcare to me; or the past, present or future payment for the provision of healthcare 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 Protect 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 that I have a right to review the Practice's Notice of Privacy Practice's 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, inwriting, at any time, except to the extent that the Chiropractor or the Practice has acted in reliance on this consent.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Van Engen Chiropractic and Health Center & New Life Chiropractic

Patient Records:
Patient records, including X-rays, are property of Van Engen Chiropractic and Health Center, and New Life Chiropractic. These records are released only with your written permission or as required legally.

Financial Matters:
Payment is due at the time services are provided unless prior arrangements have been made. All charges will be explained to you prior to any service being performed.

Insurance:
The clinic accepts assignment for most insurance coverage and will be happy to pre-verify your insurance coverage. You will need to provide your insurance card for this process.

We do not participate with Medicare but we will file for you if the status is *acute*.
We do not accept Medicaid and Tricare.

Personal Injury:
In most cases, Van Engen Chiropractic and Health Center, and New Life Chiropractic will accept assignment for payment. If Van Engen Chiropractic and Health Center, and New Life Chiropractic accepts assignment for payment, the patient is still legally responsible for their account balance. Patients will be required to sign a lien in the case of personal injuries. In this situation, you are asked to authorize direct payment to the clinic through your attorney or the insurance company and permit the endorsement to co-issued checks.

Workers Compensation:
Work-related injury cases are accepted on assignment with permission of the employer and prior authorization from the employer's compensation insurance carrier.

I have read the above statements and accept these conditions.

Print Name: _____

Signature: _____

Date: _____

Patient Representative: _____

Relationship to Patient: _____

Van Engen Chiropractic and Health Center & New Life Chiropractic

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____ (patient's name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Van Engen Chiropractic and Health Center, and New Life Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received and maintained by the Practice.

_____ _____
Date Signature

_____
Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ (patient's name) receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patient's acknowledgment, the Practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (check all that applies):

- ☐ Personally
- ☐ Mail
- ☐ Phone Follow-up
- ☐ Other _____

_____ _____
Date Signature

_____
Print Name of Chiropractor & Name of Practice