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

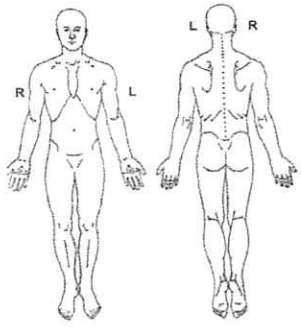
How often do you have this problem?_____ How long does the pain last?_____

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:_____

New Life Chiropractic

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I,_____ (Name of Individual) consent to New Life Chiropractic, 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 this 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 health care 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 protected 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 I have a right to review the Practices Notice of Privacy Practices 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, in writing, 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

_____

Relationship to Patient

New Life Chiropractic

Patient Records:
Patient records, including x-rays, are property of New Life Chiropractic. These records are only released 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 prior to any service being performed.

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

We **DO NOT** participate with Medicare, but will file for you if the status is acute.
We **DO NOT** accept Medicaid or Tri-Care

Personal Injury:
In most cases, New Life Chiropractic will accept assignment for payment. If New Life Chiropractic accepts assignment for payment, the patient is still legally responsible for their account balance. A lien will be signed by patient to authorize direct payment to the clinic through your attorney or insurance company and permit the endorsement to co-issued checks.

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

I have read the above statements and accept these conditions.

Print Name_____

Signature_____

Date_____

Patient Representative_____

Relationship to Patient_____

New Life Chiropractic

I, _____(PATIENTS NAME) acknowledge that I have reviewed, and understand and agree to the Notice of Privacy of 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_____

Printed 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 name) receipt of our notice privacy practices. In spite of these efforts, the practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all the 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)

_____Personally ____Mail _____Phone follow up

_____Other

Date_____

Signature_____

New Life Chiropractic

Dr. Daniel Synowicki D.C.