ROCHESTER FAMILY CHIROPRACTIC

www.RochesterFamilyChiro.com

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WELCOME.

ADULT – NEW PATIENT INTAKE

Full Name: _____ Today's Date: _____

Address: _____

Gender: ( ) Male ( ) Female Birth Date: _____/_____/_____ Age: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

Email (for office use only): _____ Marital Status: _____

Your Employer: _____ Occupation: _____

How did you hear about us? _____ If referred, whom may we thank? _____

Prior chiropractic care? ( )No ( )Yes, name/date, reason: _____

HEALTH HISTORY Please check below any past or current symptoms, even if they are not related to your current problem.

___Allergies:_____
___Arthritis(Osteo/Rheu)
___Asthma
___Bleeding Disorder
___Buttock pain
___Cancer:_____
___Carpal Tunnel
___Chest pain/ Rib
___Depression
___Disc
___Diabetes Type I / II
___Earaches/ hearing
___Eye/ vision trouble
___Fainting/ seizures
___Fracture:_____
___Fatigue
___Heart Disease
___Headaches
___Hearing difficulty
___High Blood Pressure
___High Cholesterol
___Hip pain
___Infections
___Infertility
___Insomnia
___Joints
___Kidney problems
___Leg / knee/ ankle/ foot
___Liver Disease
___Loss of balance
___Low back pain
___Menstruation
___Mental Illness
___Mid back pain
___Migraine Headaches
___Neck pain
___Osteoporosis
___Pinched nerve
___Reproductive difficulty
___Shoulder/ arm/ hand
___Sinus
___Skin disorders
___Sleep problems
___Stroke
___Seizures
___Tailbone/ sitting
___Thyroid problem
___TMJ/ jaw
___Tumors/ Growths
___Ulcers
___Urinary/ bowel movements
___Other_____

Please circle any of the above if any family member has also experienced the above conditions.

List current medications – vitamins - supplements and for what conditions they have been prescribed: _____

_____

_____

_____

Women: Last menstrual cycle date: _____ Pregnant? ( )No ( )Yes, how many weeks? _____ Due Date: _____

Thank you for choosing Rochester Family Chiropractic to be your health-care partner.
We are here to serve you and your family. If you have questions or concerns please let us know.
Your participation is important and will help determine your health results.

CONSENT TO CHIROPRACTIC CARE

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Laura Nicholson, D.C. and/or any other chiropractic personnel who may be involved in the course of my treatment. Procedures may include the following: patient history, patient exam with orthopedic, neurological and chiropractic assessment, diagnostic x-rays, report of findings, chiropractic adjustments, heat and cold therapy, therapeutic massage and reassessment exams. I understand that Dr. Nicholson and/or personnel will rely on statements about me, my medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that with all health care delivery systems, including medicine, the practice of chiropractic may have potential complications. Possible risks may include post-treatment soreness, disc injury aggravation, joint, ligament, tendon or soft tissue injury and osseous tissue injury. As for a risk of stroke, according to the journal, *Spine* 2008; 33 (4S):S176-S183, patients are no more likely to suffer a stroke following a visit to a chiropractor than they would after stepping into their family doctor's office. The potential incidence is so rare that it is considered statistically insignificant. Precautions such as pre-treatment history, examination, and x-rays prior to care minimize such risks, as well as performing all treatment carefully. Please advise your doctor if you experience any soreness, discomfort, dizziness, headache, tiredness, nausea, vomiting, loss of balance, or any other side effects or symptoms. I acknowledge, fully understand and agree to inform my medical physician of my present health condition in order to exclude any possible underlying pathology. Chiropractic is not a disease oriented treatment method, rather a focus on the body's ability to reach its maximum potential for healing.

I understand that chiropractic care involves the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me. I wish to rely on Dr. Nicholson to exercise judgment during the course of the procedure which she feels at the time, based upon the facts then known, is in my best interests. I have had an opportunity to discuss to my satisfaction with Dr. Nicholson, or other clinic personnel the nature and purpose of chiropractic adjustments and therapy procedures. By signing this form, I acknowledge that I have read or had this form read and/or explained to me and that I fully understand its contents.

Printed Name	**Signature**	**Date**

VERIFICATION OF NON-PREGNANCY (WOMEN ONLY)

I verify to the best of my knowledge I am NOT pregnant at this time and have given my permission to perform diagnostic radiographs.

Printed Name	**Signature**	**Date**

AUTHORIZATION OF PAYMENT

I authorize and request my insurance carrier to pay directly to Rochester Family Chiropractic insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Printed Name	**Signature**	**Date**

NOTICE OF PRIVACY PRACTICES

I acknowledge that Rochester Family Chiropractic "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Rochester Family Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practice describes the types of use and disclosures of my protected health information that will occur in my care, payment of my bills and/or in the performance of health care operations of Rochester Family Chiropractic. It describes my rights as they concern the limited use of health information, including my demographic information, collected from me and created or received by my physician. The Notice of Privacy Practice for Rochester Family Chiropractic is available at the main administrative desk of this practice. Rochester Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices by calling the office and requesting a copy.

Printed Name	**Signature**	**Date**