WELCOME TO OUR OFFICE

New Patient Information

All forms must be completed in ink

Date		**Are you on Medicare?** If Yes - Security Number

Personal / Contact Information

Last Name	First Name		MI

Home Address	City	State	Zip

Occupation	Employer Name	Work Phone:

Home Phone:		Cell Phone:	Email Address:	
Date of Birth	Age	Responsible Party if Minor	Gender	Marital Status

Family Information

Spouse's Last Name	Spouse's First Name	Spouse's MI	Spouse's Date of Birth

Spouse's Occupation	Spouse's Employer Name	Work Phone:

Number of Children	Child 1: First Name / Age	Child 2: First Name / Age	Child 3: First Name / Age
	Child 4: First Name / Age	Child 5: First Name / Age	

Emergency Contact Name (friend or relative)	Relationship	Phone #:

Worker's Compensation Claims

Is your present condition related to employment?	Is your present condition a result of an accident (fall, auto, etc?)

Chiropractic History

Have you ever been seen by a chiropractor before?	When?	Who?
Did he/she use Applied Kinesiology?	Who can we thank for your referral to our office?	

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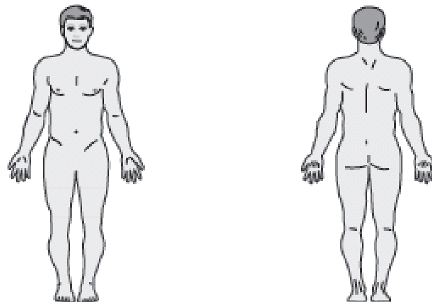
CHIEF COMPLAINT / PRESENT ILLNESS

	PROBLEM 1	PROBLEM 2	PROBLEM 3
Major problems: List and describe in order of importance.			
Date: When did it occur? (Give specific date.)			
Is it accident related? If YES, give details.			
What makes it better? (medication, heat, cold, movement, position, etc.)			
What makes it worse?			
Have you had this before? When?			
Have you seen another physician for this problem? Who?			
Were X-rays taken? What kind? Was lab work done? What tests?			

PAIN DRAWING

Please mark the areas of your pain on the outlines below.
N – Numbness **T** – Tingling **P** – Pain **W** – Weakness



RATE YOUR PAIN (0-10) ________
0 = No pain 10 = Worst pain possible

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CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. Please check any of the following symptoms that you NOW HAVE or HAVE HAD previously.

GENERAL
- ☐ Allergy
- ☐ Bruising
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headache
- ☐ Head trauma
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tingling
- ☐ Twitching/Tremors
- ☐ Weakness

EYE, EAR, NOSE, THROAT
- ☐ Clicking jaw
- ☐ Deafness
- ☐ Difficulty hearing
- ☐ Dental problems
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far Sighted
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Near sighted
- ☐ Nosebleeds
- ☐ Ringing in the ears
- ☐ Sinus infection
- ☐ Swollen glands
- ☐ Tonsillectomy

GASTROINTESTINAL
- ☐ Appendicitis
- ☐ Belching or gas
- ☐ Black or bloody stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distension of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Heart burn or indigestion
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Ulcer
- ☐ Vomiting blood
- ☐ How often do you have a bowel movement?

CARDIOVASCULAR
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Pain in legs after walk
- ☐ Pain over heart
- ☐ Cold hands / feet
- ☐ Previous heart trouble
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Pneumonia
- ☐ Tuberculosis (TB)
- ☐ Spitting up blood
- ☐ Spitting up phlegm
- ☐ Wheezing / asthma

SKIN
- ☐ Acne
- ☐ Boils
- ☐ Change in mole
- ☐ Itching
- ☐ Rashes
- ☐ Skin cancer

GENITOURINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Difficulty starting urination
- ☐ Infrequent urination
- ☐ Inability to control bladder
- ☐ Kidney stones
- ☐ Painful urination
- ☐ Sexual difficulties
- ☐ Venereal infection

WOMEN ONLY
- ☐ Breast lump or pain
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Painful menstruation
- ☐ Vaginal burn or itch
- ☐ Menstruation
  - How many days?_________
  - Days between periods?____
  - Date of last period?________
  - Date of last PAP?_________
- ☐ Menopause
  - What age?_______________

Y/N Are you pregnant now?

MEN ONLY
- ☐ Prostate problems
- ☐ Testicular swelling or pain

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Swollen joints
- ☐ Spinal curvature

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CHECK ALL CONDITIONS THAT YOU HAVE HAD:

☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Miscarriage	☐ Scarlet Fever
☐ Anemia	☐ Diabetes	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Mumps	☐ Tuberculosis
☐ Arteriosclerosis	☐ Eczema	☐ Influenza	☐ Pleurisy	☐ Typhoid Fever
☐ Arthritis	☐ Emphysema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Polio	☐ Venereal Disease
☐ Chorea	☐ Fever blisters	☐ Measles	☐ Measles	☐ Whooping Cough

FAMILY HISTORY

Check the conditions that relate to your siblings, parents and grandparents only. DO NOT INCLUDE YOURSELF.
List the relation to the right of the condition.

☐ Cancer________________________________
☐ Diabetes______________________________
☐ Heart Disease__________________________
☐ Kidney Disease_________________________
☐ Obesity_______________________________
☐ Muscle, bone or nerve disease_____________
☐ Mental/emotional disorders________________
☐ Thyroid disease_________________________
☐ Tuberculosis___________________________
☐ Acne_________________________________

PAST HISTORY

Please indicate if you have ever had the following (include date and brief description where applicable.)

Allergies:____

Past serious illness:____
____

Hospitalizations / operations:____

Fractures / dislocations / sprains:____
____

Severe trauma / accidents / falls:____

Do you smoke / use tobacco? Y/N Packs per day? ______ How many years? ______

Do you drink alcohol? Y/N Drinks per week? ______ Do you use recreational drugs? Y / N

Do you exercise? Y/N What type?________________________Times per week?_________How long?______________

Do you consistently take any vitamins / nutritional supplements?
Please List:

☐ Multivitamin ☐Other:______________________
☐ Calcium ☐Other:______________________
☐ Omega 3 / 6 / 9 ☐Other:______________________
☐ B Complex ☐Other:______________________
☐Other:_____________ ☐Other:______________________
☐Other:_____________ ☐Other:______________________
☐Other:_____________ ☐Other:______________________

Do you regularly take medications? Y / N

Prescription:	Over the Counter
☐______________________	☐______________________
☐______________________	☐______________________
☐______________________	☐______________________
☐______________________	☐______________________
☐______________________	☐______________________
☐______________________	☐______________________
☐______________________	☐______________________

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DIET HISTORY

Approximately how many of the following foods do you consume EACH WEEK?
When possible, put figures in the blank spaces.

Glasses of:
____ Whole milk
____ Skim milk
____ Buttermilk
____ Half & Half
____ Cheese
What Type? ____________________
Servings of:
____ Eggs
____ Beef
____ Pork
____ Bacon
____ Liver
____ Fowl
____ Fish
____ Bologna/deli meats
____ Canned meats
____ Cereals
____ Sugarcoated cereals
____ Pancakes
____ Waffles
____ Crackers
____ Rice
____ Pasta
____ Macaroni
____ Soup
Servings/portions of
____ Pie
____ Cakes
____ Cookies
____ Candy
____ Candy bars
____ Doughnuts/Danish
____ Ice cream
____ Jello-o
Other Desserts?____________________
Servings of vegetables
____ Potatoes (white/sweet)
____ Carrots
____ Beans (dry/string)
____ Corn
____ Parsley
____ Squash
____ Spinach
____ Mustard/turnip greens
____ Lettuce

Vegetables (Continued)
____ Celery
____ Green peas
____ Broccoli
____ Asparagus
____ Cole slaw
____ Onions
____ Tomatoes
____ Watercress
____ Green peppers
____ Cabbage
____ Turnips

Others:____________________
Servings of fruit:
____ Oranges
____ Grapefruit
____ Pineapple
____ Apples
____ Bananas
____ Watermelon
____ Prunes
____ Dates
____ Raisins
____ Figs
____ Grapes
____ Applesauce
____ Dried fruit
____ Canned fruit
____ Frozen fruit
____ Others: ____________________
Servings of:
____ Popcorn
____ Peanuts
____ Peanut butter
____ Other nuts: ____________________
____ Glasses of juice
What kinds? ____________________
____ Glasses of soft drinks / colas
What kinds? ____________________
____ Regular coffee
____ Decaf coffee
____ Teaspoons of sugar / day

What oils do you use for cooking? ______
____
What oils do you use in salads?
____

What did you eat yesterday for:
Breakfast? ____________________
Lunch? ____________________
Dinner? ____________________

What did you have to drink? ______
____
Did you snack between meals? Y/N
What? ____________________

How many per DAY?
____ Pats of butter
____ Pats of margarine
____ Slices of white bread
____ Whole Wheat bread
____ Other bread________________

____ Glasses of water
____ Coffee
____ Tea
____ Alcohol

Do you use salt:
Sparingly / freely / moderately?

Is this your average diet for the last 3 years? Y/N
What foods disagree with you?________
____
Do you have indigestion Y/N

Are you fond of:

Meats?	Y/N
Fats?	Y/N
Sweets?	Y/N
Vegetables	Y/N
Fruits?	Y/N
Bread	Y/N

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SIGNATURE PAGE

Please read the following documents:

- Consent to Chiropractic Treatment
- Notice of Privacy Practices

Sign your agreement on this form which will be a part of your records. You may keep the consent and HIPPA documents for your reference.

Thank you!

CONSENT TO CHIROPRACTIC EXAMINATION / TREATMENT

I hereby authorize Dr. Eileen Psencik and whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:______________________________ Date: ____________________

HIPPA – PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Greenville Avenue Chiropractic.

Signature:______________________________ Date:____________________

CONSENT TO TREATMENT OF A MINOR (IF APPLICABLE)

I hereby authorize Greenville Avenue Chiropractic, Dr. Eileen Psencik, and whomever is designated as assistants to administer chiropractic examination, treatment as deemed necessary to my child.

Name of Child:______________________________

Signature of Parent / Guardian:____________________Date: ____________________

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CONSENT TO CHIROPRACTIC TREATMENT

The primary treatment used is the spinal adjustment.
We may use this procedure to treat you.

1. **THE NATURE OF CHIROPRACTIC ADJUSTMENT**

   We will use our hands or a mechanical device on your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sensation of movement.

2. **THE MATERIAL RISK INHERENT IN CHIROPRACTIC ADJUSTMENT**

   As with many health care procedures, there are certain complications, which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients feel some stiffness and soreness following the first few days of treatment.

3. **PROBABILITY OF THOSE RISKS OCCURING**

   Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during the examination and/or x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination, which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Please sign the "Signature Page" for our records. You may keep this copy for your records.

I hereby authorize Dr. Eileen Psencik and whoever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

Signature:______________________________ Date: ____________________

In signing this HIPAA Patient Ack..wledgement form, you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records ..y be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Greenville Avenue Chiropractic Applied Kinesiology must have my consent, therefore, I authorize Greenville Avenue Chiropractic Applied Kinesiology to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)
☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. physician(s), other healthcare providers, care givers, family members and other specified person/persons)

..ame:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Name:______________________________ Relationship:______________________________

Contact Information:

I authorize Greenville Avenue Chiropractic Applied Kinesiology to contact me at the following number with results or questions:

Home____________________ Cell____________________ Work____________________

Email: ____

May we leave a detailed message on your answering machine or voicemail?

Yes☐ No☐ Failure to check one of these boxes may delay results

By Patient:
(Print and sign)____ Date:__________

..r Patient's Representative
(Print name, sign and describe authority)______________________________________ Date:__________