New Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment.
All information is strictly CONFIDENTIAL.

Patient Data			
First Name:	Last Name:	Date:	Email:

***Your email will NOT be shared with any 3rd parties, and is used for sending receipts.**

Mailing Address				
Address:	City:	State:	Zip:	
Telephone (mobile):	Telephone (work):	Referred By:		
Age: Birth Date:	Marital Status:	Spouse's Name:	Number of Children:	
Occupation:	Employer:	Emergency Contact:	Phone:	

Current Complaints
Nature of Injury: ▢ Automobile* ▢ Work ▢ Other
Please Describe:
Date of Injury: Date Symptoms Appeared:
Have you ever had the same injury? ▢ Yes ▢ No If yes, when?
List of other practitioners seen for this injury/condition?
Have you ever been under chiropractic care? ▢ Yes ▢ No * If yes, please describe: _____

Payment Information
Name of party responsible for payment: Phone:
Do you have BADGERCARE/MEDICAID/MEDICARE insurance? ▢ Yes ▢ No Name of Company:
***IF AUTO ACCIDENT OR WORKERS COMPENSATION, PLEASE PROVIDE:**
Insurance Company Name: Contact Person: Phone: Claim Number:

Signatures

Name of the insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that ALL services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date _____
Parent/Guardian Signature _____ Date_____

PRIORITY WELLNESS CHIROPRACTIC CENTER

Medical History
Have you ever been treated for any conditions in the last year? ▢ Yes ▢ No If yes, please describe:
Is there any chance you are pregnant? ▢ Yes ▢ No
Have you had X-rays taken? ▢ Yes ▢ No If yes, Where?
What medications are you taking and for what conditions? (please list dosage and amounts, etc).
What vitamins, minerals, or herbs do you currently take? (please list for what conditions, dosage, and frequency).

Have you ever:	**YES**	**NO**	**Briefly Explain**
Broken Bones?	▢	▢	
Been Hospitalized	▢	▢	
Been in an auto accident?	▢	▢	
Had sprains/strains?	▢	▢	
Been struck unconscious?	▢	▢	
Had surgery?	▢	▢	

Do you experience pain everyday?	▢ Yes ▢ No
Do your symptoms interfere with everyday life?	▢ Yes ▢ No
Does pain wake you up at night?	▢ Yes ▢ No
Is your pain worse at certain times of the day?	▢ Yes ▢ No
Do changes in weather affect your symptoms?	▢ Yes ▢ No
Do you wear orthotics?	▢ Yes ▢ No
What activities aggravate your symptoms?	

Family History- (Diabetes, cancer, arthritis, high blood pressure, etc.)

Have you ever suffered/currently suffering from:

☐ Alcoholism ☐ Allergies ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma

☐ Back Pain ☐ Breast Lump ☐ Bronchitis ☐ Bruise Easily ☐ Cancer ☐ Chest Pain/Conditions

☐ Cold Extremities ☐ Constipation ☐ Cramps ☐ Depression ☐Diabetes ☐ Digestion Problems

☐ Dizziness ☐ Ears Ring ☐ Excessive Menstruation ☐ Eye Pain or Difficulties ☐ Fatigue

☐ Frequent Urination ☐ Headache ☐ Hemorrhoids ☐ High Blood Pressure ☐ Hot Flashes

☐ Irregular Heart Beat ☐ Irregular Cycle ☐ Kidney Infection ☐ Kidney Stones ☐ Loss of Memory

☐ Loss of Balance ☐ Loss of Smell ☐ Loss of Taste ☐ Lumps in Breast ☐ Neck Pain or Stiffness

☐ Nervousness ☐ Nosebleeds ☐ Pacemaker ☐ Polio ☐ Poor Posture ☐ Prostate Trouble

☐ Sciatica ☐ Shortness of Breath ☐ Sinus Infection ☐ Sleep Problems or Insomnia ☐ Spinal Curvatures

☐ Stroke ☐ Swelling of Ankles ☐ Swollen Joints ☐ Thyroid Condition ☐ Tuberculosis

☐ Ulcers ☐ Varicose Veins ☐ Venereal Disease ☐ Other: _____

Habits:

None (N) Light (L) Moderate (M) Heavy (H)

PLEASE CIRCLE BELOW

Alcohol- N L M H

Coffee- N L M H

Tobacco- N L M H

Drugs- N L M H

Exercise- N L M H

Sleep- N L M H

Appetite- N L M H

Soft Drinks- N L M H

Water- N L M H

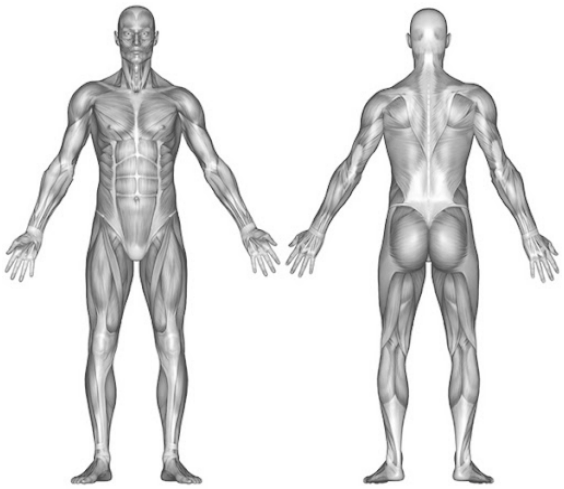
Salty Foods- N L M H

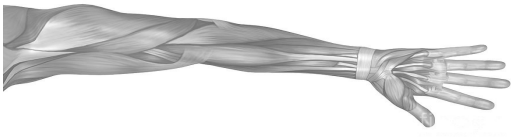
Sugary Foods- N L M H

Artificial Sweeteners- N L M H

Please use the following letters to indicate the TYPE and LOCATION of the symptoms you are currently experiencing

A- Ache B- Burning N-Numbness P- Pins and Needles S- Stabbing O- Other





PRIORITY WELLNESS CHIROPRACTIC CENTER

Informed Consent for the Chiropractic Patient:

To the Patient: Please read document and sign. It is important that you understand the information contained in this document.

The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. He or she may use her hands or mechanical instrument upon 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 sense of movement.

Analysis/Examination/Treatment: As part of the analysis, examination and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, trigger point massage, range of motion testing, orthopedic testing, neurological testing, muscle strength testing, postural analysis testing, ultrasound, cold therapy, biofreeze application, electric muscle therapy, and traction therapy.

The risks inherent in chiropractic adjustment: As with any other healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy that are very rare such as fractures or minor muscle pulls. It is common to feel stiffness or soreness following the first few days of treatment. Fractures are very rare occurrences and generally result from some underlying weakness of the bone. Stroke or vertebral artery dissection caused by chiropractic manipulation of the neck has not been officially proven but continues to be anecdotal. The doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would not come to the Doctor's obvious attention, it is your responsibility to inform the doctor.

Authorization for the release of patient information: I hereby authorize Stephens DBA Priority Chiropractic to provide other health care providers with information regarding my healthcare as deemed appropriate. I give my permission for the use of medical records, including x-rays and information shared during the process of examinations and treatment to be released to insurance companies, other doctors, health consultants and or staff involved in my care.

Do not sign until you have read and understand the above. I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have had all my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to understand the treatment recommended. I hereby give my consent to chiropractic treatment and authorize any pertinent medical records exchange. I understand this consent to be effective until I am notified otherwise.

Date:_____

Patient's Signature:_____

Signature of parent/guardian (if minor)_____

225 S Main Street Rice Lake WI 54868