GEAUX CHIRO
CHIROPRACTIC & HEALTH

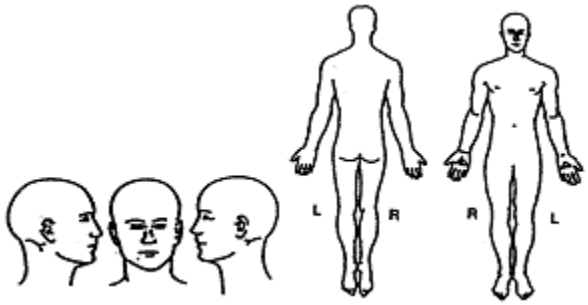
(OFFICE USE) Scanned: □HSQ □ID □Ins (□ABN □AG □LoG) □AAQ/S&F

Date: _____

NEW PATIENT HEALTH REVIEW

Last: _____ First: _____ Middle Initial: _____ Sex: □ M □ F
Mailing Address: _____ City/State/Zip: _____
Cell Phone: _____
Email: _____ (for receipts, updates, promos, etc.)
DOB:_____ Age: _____ Social Security # (*last 4 digits required*):_____
Patient's or Parent's Employer : _____ Position: _____
Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated
Name of Spouse: _____
Spouse's Employer: _____ Phone:_____
Emergency Contact:_____
Women: Are you pregnant or possibly pregnant? □ yes □ no
Reason for visit:_____
When did your symptoms appear? _____
Is this condition progressively getting worse? □ yes □ no □ unknown
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of Pain: (check all that apply)
□ sharp □ dull □ throbbing □ numbness □ aching □ shooting □ burning □ tingling
□ cramps □ stiffness □ swelling □ other: _____
How often do you have this pain? □ constant □ frequent □ intermittent □ occasional
Does it interfere with your (check all that apply): □ work □ sleep □ daily routine □ recreation
Activities or movements that are painful to perform: □ sitting □ standing □ walking □ bending □ lying down
What other health care have you received for this problem?
□ medication □ surgery □ physical therapy □ chiropractic services □ none □ other:_____
Other doctor(s) who have treated you for this condition. _____

Please mark on the picture the area of discomfort:



Is this condition due to an accident? □ Yes (Date: _____) □ No
If yes… Type of accident: □ auto □ work □ home □ sports □ other: _____
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker's Comp. □ Other: _____
Attorney name (if applicable):_____
Have you lost any time from work? □ yes □ no Dates: _____

Medical History:

Circle YES or NO to indicate if you have had or currently have any of the following:

AIDS/HIV	Y	N	Gonorrhea	Y	N	Pneumonia	Y	N
Alcoholism	Y	N	Gout	Y	N	Polio	Y	N
Allergy Shots	Y	N	Heart Disease	Y	N	Prostate Problem	Y	N
Anemia	Y	N	Hepatitis	Y	N	Prosthesis	Y	N
Anorexia	Y	N	Hernia	Y	N	Psychiatric Care	Y	N
Appendicitis	Y	N	Herniated Disc	Y	N	Rheumatoid Arthrosis	Y	N
Arthritis	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	High Blood Pressure	Y	N	Scarlet Fever	Y	N
Bleeding Disorder	Y	N	High Cholesterol	Y	N	STD	Y	N
Breast Lump	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Bronchitis	Y	N	Liver Disease	Y	N	Suicide Attempt	Y	N
Bulimia	Y	N	Measles	Y	N	Thyroid Problems	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Tonsillitis	Y	N
Cataracts	Y	N	Miscarriage	Y	N	Tuberculosis	Y	N
Chemical Dependency	Y	N	Mononucleosis	Y	N	Tumors, Growths	Y	N
Chicken Pox	Y	N	Multiple Sclerosis	Y	N	Typhoid Fever	Y	N
Diabetes	Y	N	Mumps	Y	N	Ulcers	Y	N
Emphysema	Y	N	Osteoporosis	Y	N	Vaginal Infections	Y	N
Epilepsy	Y	N	**Pacemaker**	Y	N	Whooping Cough	Y	N
Fracture	Y	N	Parkinson's Disease	Y	N			
Glaucoma	Y	N	Pinched Nerve	Y	N			

Exercise:
- □ None
- □ Moderate
- □ Daily
- □ Heavy

Work Activity:
- □ Sitting
- □ Standing
- □ Light Labor
- □ Heavy Labor

Habits:
- □ Smoking (Packs/Day _____)
- □ Alcohol (Drinks/Week _____)
- □ Coffee/Caffeine Drinks (Cups/Day _____)
- □ High Stress Level (Reason _____)

Injury/Surgery History:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications:

_____
_____
_____

Allergies:

_____
_____
_____

Vitamins/Herbs/Minerals:

_____
_____
_____

Family History:

	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Stroke	Kidney Disease	Anemia	Mental Illness	Headaches	Osteoporosis	Arthritis	Joint Problems	Scoliosis	Back Problems	Disc Problems	Congenital Defects	Genetic Disease	Other	Deceased
Father																			
Mother																			
Brothers																			
Sisters																			
Children																			

Restriction of the Activities of Daily Living (ADLs)

	Have Not Performed	No Pain or Difficulty	Mild Pain or Difficulty	Moderate Pain or Difficulty	Severe Pain or Difficulty	Unable to Perform
Routine Activities						
Bathing	0	1	2	3	4	5
Getting on/off the toilet	0	1	2	3	4	5
Shampooing/grooming hair	0	1	2	3	4	5
Putting on/taking off shoes/socks	0	1	2	3	4	5
Putting on/taking off clothing	0	1	2	3	4	5
Brushing your teeth	0	1	2	3	4	5
Cleaning	0	1	2	3	4	5
Heavy carrying (groceries, garbage)	0	1	2	3	4	5
Cooking	0	1	2	3	4	5
Washing the car	0	1	2	3	4	5
Postural Activities						
With prolonged sitting	0	1	2	3	4	5
With prolonged standing	0	1	2	3	4	5
With prolonged walking	0	1	2	3	4	5
Climbing stairs	0	1	2	3	4	5
Bending	0	1	2	3	4	5
Laying on your stomach	0	1	2	3	4	5
Laying on your back	0	1	2	3	4	5
Squatting/kneeling	0	1	2	3	4	5
Driving Activities						
Turning your head	0	1	2	3	4	5
Rotating your body	0	1	2	3	4	5
Prolonged sitting as driver/passenger	0	1	2	3	4	5
Riding on a bumpy road	0	1	2	3	4	5
Recreational Activities						
Participating in aerobic activities	0	1	2	3	4	5
Running or jogging	0	1	2	3	4	5
Weightlifting	0	1	2	3	4	5
Sleep Habits						
Take longer to fall asleep	0	1	2	3	4	5
Sleep is interrupted	0	1	2	3	4	5
Can't fall asleep without medication	0	1	2	3	4	5

PATIENT HISTORY

I acknowledge that I have answered all the above information to the best of my ability.

NOTICE OF PRIVACY

I acknowledge that I have received Geaux Chiro Chiropractic & Health's Notice of Privacy Practices for protected health information.

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on myself or on _____(minor), by the licensed Doctor of Chiropractic and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures for my condition and for any future conditions for which I seek treatment.

INSURANCE

We welcome you as a new patient and want you to be clear on your financial responsibility for care at our clinic.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This consent will end when my current treatment plan is complete or five years from the date signed below.

If you have health insurance, we will call and verify your coverage. This will be explained to you and the terms of your coverage will be in your chart. You will be responsible for any non-covered expenses such as ice packs, vitamins, back braces, pillow, etc. You are also responsible for all costs associated with your deductible and co-payments.

As a courtesy, this office will provide you with your insurance benefits and will file all insurance claims. Please note that you will either have a copay or will be required to pay towards your deductible at each visit. If your deductible has been met, most insurance companies will cover a percentage of treatment billed. Once you have met your out-of-pocket maximum, most insurance companies will cover 100% of all eligible expenses for the remainder of the calendar year. If there is a question about your personal balance, please feel free to contact us at your convenience. Please note that this may be done by telephone, or feel free to do this at the time of one of your therapy sessions.
Please sign and date this letter stating that you are aware of your insurance benefits and that you know that you will be required to pay all co-pays, unmet individual deductibles, and out of pocket maximums at the time that services are rendered.

_____ _____

Patient's Name (Printed) Patient's Signature

_____ _____

Date Relationship or authority if not signed by the patient

(FOR OFFICE USE ONLY – Please do not sign below this line)

_____

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the patient the Notice of Privacy Practices posted in our office.
- ☐ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ☐ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ☐ Asking the patient to sign this Acknowledgement form.
- ☐ Other (explain in detail) _____
  _____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form.
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail) _____
  _____

Date: _____ Name: _____

Notes: This written acknowledgement must be completed no later than the first date health care service or treatment is provided to the patient. This acknowledgement must be retained in the patient's permanent records.