Wild Rivers Chiropractic

New Patient Information

Full Name _____ Age _____ Date of birth _____

Preferred Name _____ ☐ Female ☐ Male ☐ Other _____

Guardian Name (if applicable) _____

Home Phone _____ Cell Phone _____

Email Address _____

Address _____ City _____ State____ Zip _____

Family Physician _____May we forward our findings to your doctor? ☐ Yes ☐ No

Emergency Contact _____Relation _____ Phone _____

Employer _____

Name of Health Insurance _____

ID# _____ Group#_____ Relation to Insured: ☐ Self ☐ Spouse ☐ Child

Policy Holder DOB: _____ Policy Holder Address _____

How did you hear about us? _____

History of Present Illness

Reason for today's visit: _____

_____

How did your symptoms begin _____ Date of onset _____

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What describes the nature of your symptoms? _____

☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning ☐ Numbness ☐ Tingling ☐ Other: _____

Does the pain radiate or travel? ☐ Yes ☐ No If yes, please describe: _____

Indicate the average intensity of your symptoms or pain (please circle):

0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse ☐ Comes/goes

Does it interfere with your daily routine? ☐ Yes ☐ No Please explain: _____

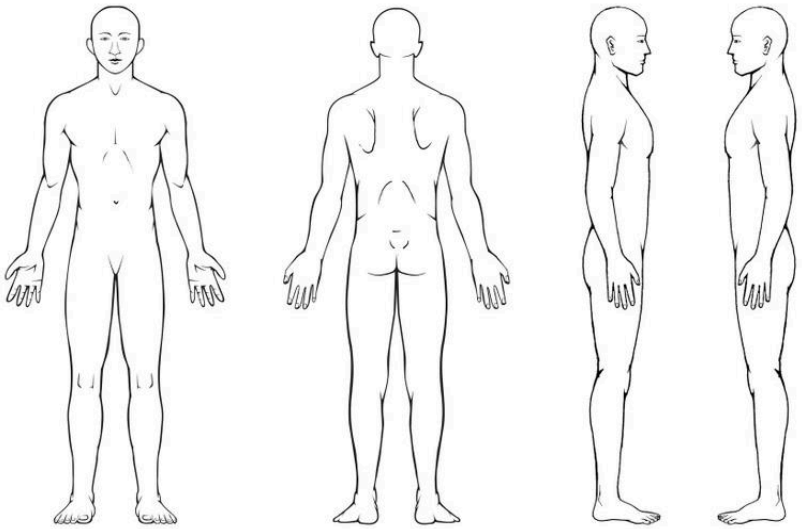
What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you had the same/similar symptoms before? ☐ Yes ☐ No If yes, date of prior condition _____

Other providers seen for this condition: _____

Mark Areas of Pain on Figures Below



Check all symptoms that apply to you:

- ☐ Lethargy/Weakness
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Recent weight loss or gain
- ☐ Headaches
- ☐ Night sweats
- ☐ Neck pain/stiffness
- ☐ Back pain/stiffness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Tingling/numbness in arms/hands
- ☐ Tingling/numbness in legs/toes
- ☐ Loss of balance/dizziness
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Blood in Urine
- ☐ Pain unrelieved by rest

Medical History

Previous Hospitilizations/Traumas/Surgeries_____

_____

_____

Auto Accident_____ Date _____

Other personal injury or accidents _____ Date _____

Ongoing illnesses_____

Allergies (Medicine, Food, Environment) _____

Current Medications_____

_____

Do you have a PERSONAL or FAMILY history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other Serious Illnesses _____

Habits: ☐ Alcohol ☐ Coffee ☐ Tobacco ☐ Drugs

Have you had chiropractic care before? ☐ Yes ☐ No _____

Review of Systems

HEENT

- ☐ Headaches
- ☐ Eye or vision problems
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Sinus trouble
- ☐ Ear or hearing problems
- ☐ Dental/Gum problems
- ☐ TMJ problems
- ☐ Other: _____

Skin/Hair

- ☐ Skin trouble or Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Easy bruising
- ☐ Other: _____

Cardiovascular

- ☐ Chest Pain
- ☐ Heart attack
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Swelling of feet or hands
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Blood clots
- ☐ Pacemaker
- ☐ Mitral valve prolapse
- ☐ Other: _____

Respiratory

- ☐ Chronic or frequent cough
- ☐ Spitting up blood
- ☐ Asthma or wheezing
- ☐ Shortness of breath
- ☐ Exercise intolerance
- ☐ Sleep apnea
- ☐ Emphysema
- ☐ Snoring issues
- ☐ Breathing or lung issues
- ☐ Other: _____

Gastrointestinal

- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Stomach ulcer
- ☐ Bloating/Cramping
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Difficulty swallowing
- ☐ Change in bowel habits
- ☐ Other: _____

Neurological

- ☐ Frequent headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory Loss
- ☐ Poor balance
- ☐ Numbness or tingling
- ☐ Pins and needles
- ☐ Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Head injury
- ☐ Sleeping issues
- ☐ Weak muscles
- ☐ Other: _____

Muskuloskeletal

- ☐ Arthritis
- ☐ Joint pain or swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Trauma
- ☐ Osteoporosis
- ☐ Cramping
- ☐ Fractures
- ☐ Implants, plates, pins, or screws
- ☐ Hip disorders
- ☐ Knee injuries
- ☐ Foot/ankle pain
- ☐ Shoulder problems
- ☐ Other: _____

Psychiatric

- ☐ Alzheimer's Disease
- ☐ Insomnia
- ☐ Difficulty concentrating
- ☐ Memory loss/confusion
- ☐ Depression
- ☐ Anxiety
- ☐ Agitation/ Irritability
- ☐ Suicidal thoughts
- ☐ Chemical dependency
- ☐ Other: _____

Endocrine

- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Sweating
- ☐ Hear intolerant
- ☐ Cold Intolerant
- ☐ Weight loss
- ☐ Weight gain
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Change in appetite
- ☐ Hair changes
- ☐ Hyperthyroidism
- ☐ Steroid treatments
- ☐ Other: _____

Urinary

- ☐ Painful or frequent urination
- ☐ Incontinence
- ☐ Hesitancy
- ☐ Urgency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Other: _____

Blood/Lymph

- ☐ Anemia
- ☐ Bleeding
- ☐ Bruising
- ☐ Blood clots
- ☐ Past transfusions
- ☐ Leukemia
- ☐ Lymphoma
- ☐ HIV/AIDS
- ☐ Other: _____

Female

- ☐ Painful sex
- ☐ Vaginal discharge
- ☐ Breast pain or lumps
- ☐ Hot flashes
- ☐ Menstrual irregularity
- ☐ Loss of libido
- ☐ Menopause
- ☐ Sexually transmitted disease
- ☐ Other: _____

Male

- ☐ Dribbling
- ☐ Loss of libido
- ☐ Erectile dysfunction
- ☐ Sexually transmitted disease
- ☐ Testicular pain or lumps
- ☐ Prostate disease
- ☐ Penile discharge
- ☐ Other: _____

After reading and filling out the case history, your signature will verify that all the information you have given is correct to the best of your knowledge.

_____

Signature ***Date***

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

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 on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. DeSantis and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Wild Rivers Chiropractic LLC for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct Wild Rivers Chiropractic LLC, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date _____

Witness _____