NEW HORIZONS
FAMILY CHIROPRACTIC

Patient Information

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Work #: _____ Occupation: _____ Employer: _____

Email: _____

Marital Status: _____ Spouse &/or Children: _____

How did you hear about us? _____ Hobbies: _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No - How recently?_____

Current Main Complaint/Symptoms

Present/Major Complaint: _____

When did this complaint started: _____

Describe the quality of this complaint: ☐ Ache ☐ Burning ☐ Deep ☐ Discomfort ☐ Dull ☐ Intense ☐ Mild

☐ Numb ☐ Sharp ☐ Shooting ☐ Stiff ☐ Superficial ☐ Throbbing ☐ Tight ☐ Tingling

☐ Other_____

Intensity: ☐ 0 (no complaint) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (worst)

Frequency: ☐ Rarely (0-25%) ☐ Occasionally (25-50%) ☐ Frequently (50-75%) ☐ Constantly (75-100%)

Since it started is this complaint: ☐ Better ☐ Worse ☐ Same

When is the complaint at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Throughout the day

What aggravates this complaint? _____

What relieves this complaint? _____

Have you been under medical care/medications recently for this problem? ☐ Yes ☐ No _____

Office/Doctor's notes:

_____

_____

_____

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How would you rate the following?

Stress Level:	None	1	2	3	4	5	6	7	8	9	10	High
Exercise Level:	None	1	2	3	4	5	6	7	8	9	10	High
Nutritional Level:	Poor	1	2	3	4	5	6	7	8	9	10	Good
Interest in your Health:	None	1	2	3	4	5	6	7	8	9	10	High

Other Symptoms:

☐ Headaches
☐ Breathing problems
☐ Neck pain/stiffness
☐ Ear infections
☐ Vision problems
☐ Heart conditions
☐ Mid-back problems
☐ Arms/hands numb
☐ Loss of smell
☐ Chest pains
☐ Low back problems
☐ Numbness in toes
☐ Ears ring
☐ Stomach issues
☐ Shoulder problems
☐ Hemorrhoids
☐ Loss of taste
☐ Diarrhea
☐ Knee problems
☐ Fever
☐ Loss of touch/feeling
☐ Constipation
☐ Ankle problems
☐ Fainting
☐ Dizzy/off balance
☐ Pain with urination
☐ Allergies
☐ Tension/irritability
☐ Jaw/chewing issues
☐ Pain with bowels
☐ Fatigue/low energy
☐ Depression
☐ Problems swallowing
☐ Abnormal bleeding
☐ Cold hands/feet
☐ ADD/ADHD
☐ Heartburn/GERD
☐ Reproductive issues

Other Health notes/concerns: _____

_____

List any medications you are currently taking: _____

_____

Have you ever been in an accident? ☐ Yes ☐ No ☐ Work ☐ Auto ☐ Other: _____

Nature of Accident: _____When? _____

Surgery(s): _____

Hospitalizations/Illnesses/Infections: _____

For Women: ☐ Pregnant ☐ Nursing ☐ Birth Control ☐ Painful Periods ☐ Irregular Cycles ☐ Other: _____

Patient Authorization

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office: New Horizons Family Chiropractic. I authorize New Horizons Family Chiropractic and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: _____ Date: _____

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Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I understand all nutritional, dietary, and health recommendations are not to treat any disease or condition(s) the patient may have but to support the Chiropractic care provided and health of the individual.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Release

This is to certify that Dr. Chris &/or Jessica Schumann &/or whomever he/she may designate as his/her assistant has my permission to perform an X-ray evaluation. To the best of my knowledge I am not pregnant, and I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Consent to Care for Minor

I authorize Dr. Chris &/or Jessica Schumann &/or whomever he/she may designate as his/her assistant to administer care as he/she so deeds necessary to my son/daughter.

Insurance/Finance

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Dr. Chris &/or Jessica Schumann and their 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 Drs. Schumann or their associates will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits. I understand that all services rendered me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered me will be immediately due and payable. Any credit accrued on an account will not be applied until the service is rendered. I understand that all finances in this office pertaining my care or supplement needs here are my full personal responsibility.

I have read and understand the above and I agree to these policies and procedures.

☐ Terms of Acceptance ☐ Patient Health Information Consent Form ☐ X-ray Release ☐ Minor Consent ☐ Insurance/Finance

Signature: _____ **Date:** _____