Birks Chiropractic & Wellness Center

NEW PATIENT HEALTH HISTORY

First Name:_____ MI: ___ Last Name: _____ Date___/___/____
Address: _____ City: _____State:_____Zip:_____
Home Phone: _____Cell Ph: _____Work Ph:_____
Email: _____
*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements or promotions.
Birth Date: _____ Marital Status: _____
Occupation: _____Employer: _____
Emergency Contact: _____Phone:_____ _____
Spouse's Name: _____Spouse Birth Date: _____*For insurance purposes.
How were you referred? _____

Appointment Reminders: (Circle One) TEXT VOICEMAIL NO REMINDER

Current Problem Describe Symptoms:
_____
_____
Pain scale (circle):No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain
What activities of daily living are affected? _____
For the following questions circle what is true for your condition:
Have you ever had the same condition? NO YES If yes, when? _____
Does the pain radiate into your(Check): _____Arm ____Leg _____Doesn't radiate
Do you experience numbness or tingling? NO YES Did the pain come on Gradually or Suddenly?
Do you have a congenital (birth) condition? NO YES If yes, what is the condition? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____
Previous treatments for this condition, including self-treatment?_____
Have you ever been under Chiropractic care? NO YES
If so, what condition were you treating?_____
Social History: Do you smoke? NO YES How much? _____ How long? _____
How much caffeine beverages in a day? _____
How much alcohol do you consume in a week? _____
Do you exercise? NO YES How much? LIGHT MODERATE HEAVY
Has your weight changed significantly in the past year? NO YES
How many hours of sleep do you get a night? _____

In order to provide you the best possible wellness care, please complete the form.
All information is strictly CONFIDENTIAL.

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CIRCLE HAD OR HAVE FOR ANY THAT APPLY

Musculoskeletal:
Had Have Neck Pain
Had Have Back Pain
Had Have Muscle Weakness
Had Have Leg Cramps
Had Have TMJ Issues
Had Have Arm/Hand Pain
Had Have Broken Bones
Had Have Swelling of Joints
Had Have Osteoporosis
Had Have Scoliosis

Neurological:
Had Have Tremors
Had Have Dizziness/Fainting
Had Have Head Injury
Had Have Anxiety
Had Have Depression
Had Have Headache
Had Have Stroke
Had Have Numbness/Tingling
Had Have Balance Problems
Had Have Memory Confusion
Had Have Seizures

Urinary:
Had Have Pain with Urination
Had Have Difficulty Urinating
Had Have Frequent Infections
Had Have Blood in Urine
Had Have Incontinence
Had Have Kidney Infections
Had Have Urgency to Urinate
Had Have Water Retention
Had Have Bedwetting
Had Have Kidney Stones
Had Have Swelling

Gastrointestinal:
Had Have Changes in Bowel Habits
Had Have Changes in Appetite
Had Have Nausea
Had Have Heartburn
Had Have Anorexia/Bulimia
Had Have Diarrhea
Had Have Constipation

Cardiovascular/Respiratory:
Had Have High Cholesterol
Had Have High Blood Pressure
Had Have Low Blood Pressure
Had Have Emphysema
Had Have Pneumonia
Had Have Chest Pain
Had Have Excessive Coughing
Had Have Difficulty Breathing
Had Have Asthma
Had Have Irregular Heartbeat
Had Have Coughing up Blood
Had Have Poor Balance
Had Have Wheezing
Had Have Easy Bruising/Bleeding

Endocrine:
Had Have Thyroid Issues
Had Have Low Energy
Had Have Immune Disorders
Had Have Excessive Thirst
Had Have Frequent Urination
Had Have Diabetes
Had Have Frequent Sweating
Had Have Dry Skin

Eyes:
Had Have Blurred Vision
Had Have Cataracts
Had Have Dry Eyes
Had Have Glasses/Contacts
Had Have Itchy Eyes
Had Have Glaucoma
Had Have Eye Pain

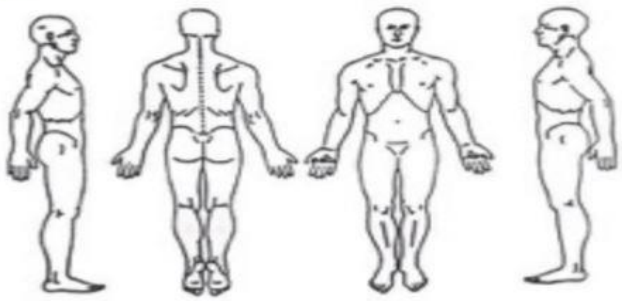
Integumentary/Skin:
Had Have Skin Cancer
Had Have Psoriasis
Had Have Eczema
Had Have Allergy Shots
Had Have Rash/Hives
Had Have Hair Loss

Ears:
Had Have Hearing Loss
Had Have Ringing in the Ears
Had Have Chronic Ear Infections

Nose:
Had Have Loss of smell/ Pressure or Pain
Had Have Allergies

Females/Males:
Had Have Infertility
Had Have Irregular Cycles
Had Have Prostate Problems
Had Have Erectile Dysfunction
Had Have Hernia

MARK AREAS OF CONCERN:



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Medical History

Have you been treated for any conditions in the last year? NO YES If yes, please describe:

_____

Date of last physical exam and Doctor_____

Women: Is there a chance that you are pregnant? NO YES Date of Last Menses: _____

Have you had X-rays or a MRI taken? NO YES If yes, where & when? _____

CHECK WHAT APPLIES: YES NO EXPLAIN:

Medications

_____

Allergies

_____

Auto Accidents

_____

Surgeries

_____

Traumas/Other

_____

Family History

Family Members - Present and past health conditions (Example: Heart disease, cancer, diabetes, arthritis, etc.) Family Member: (ie.mother, father) Condition:

_____ _____

_____ _____

_____ _____

I CERTIFY THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature:_____Date: _____

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Informed Consent for Care

You are the decision maker for your health care. This informed consent involves your understanding and agreement regarding the care we recommend the benefits and risks associated with the care, alternatives, the potential effect on your health if you choose not to receive the care and any of the fees for the services being provided to you by Birks Chiropractic and Wellness Center SC. Chiropractic care involves what is known as a chiropractic adjustment and possible additional supportive procedures or recommendations as well. Potential benefits of an adjustment include restoring normal joint motion, reducing pain, swelling and inflammation in a joint, and improving neurological function and overall well-being. We may conduct chiropractic, massage therapy, acupuncture, diagnostic or examination procedures if clinically indicated that will be carefully performed but may be uncomfortable. It is important you understand, as with any health care approach, results are not guaranteed, and there is no promise to cure. As with all types of health care, there are some risks, including but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, broken bones, disc injuries, dislocations, strains, sprains and strokes. With respect to stroke, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing and driving. Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients, who experience the condition often, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to 1 in 1 million to 1 in 2 million cervical adjustments. It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already and you have the right to a second opinion about your circumstances and health care as you see fit.

I understand that if I am accepted as a patient by Birks Chiropractic and Wellness Center SC, I have read, or have had read to me, the above consent. I understand and agree that health insurance policies are an arrangement **between an insurance carrier and me**. 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 treatment, any fees for professional services rendered to me will be immediately due and payable. **I understand that I am financially responsible for all services rendered to me or my dependent at Birks Chiropractic and Wellness Center SC and will abide by the financial policy including, but not limited to, the missed appointment policy.**

I hereby authorize Birks Chiropractic and Wellness Center SC to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf, I understand that I am financially responsible for any remaining balance. I further authorize my insurance company to direct payment to Birks Chiropractic and Wellness Center SC on my behalf. I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan. I understand that results are not guaranteed. I am authorizing them to proceed with any treatment that may be necessary. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance for which I or my dependent seek chiropractic care from Birks Chiropractic and Wellness Center SC.

Signature of Patient:_____Date:_____
Printed Patient Name: _____

Legal Guardian's Printed Name_____Signature_____

In order to provide you the best possible wellness care, please complete the form.
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