GLOYESKE
FAMILY CHIROPRACTIC

## New Patient Paperwork

**Name:**_____ **Today's Date:** _____ **Referred by:** _____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Home Phone:**_____ **Cell:** _____ **Work:** _____

**Birthday:**_____ **Age:** _____ **Gender:** ☐ Male ☐ Female **Are you pregnant?** ☐ No ☐ Yes

**Employer:**_____ **Occupation:** _____

**e-Mail:**_____ **Have you been to a chiropractor previously?** ☐ No ☐ Yes

**Emergency Contact:**_____ **Relation:** _____**Phone:** _____

**Primary Care Doctor:**_____ **Phone:** _____

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**Major Complaint:**_____ **When it began:** _____

**Type:** ☐ Dull ☐ Ache ☐ Sharp ☐ Numb/Tingle **Pain moves from:**_____

**The pain is:** ☐ Constant ☐ Occasional **Pain Rating 0 to 10 [ 0 = no pain, 10 = Disabling]**_____

**The pain is:** ☐ Worsening ☐ Stays the Same ☐ Improving ☐ Worse in the Morning ☐ Worse at Night

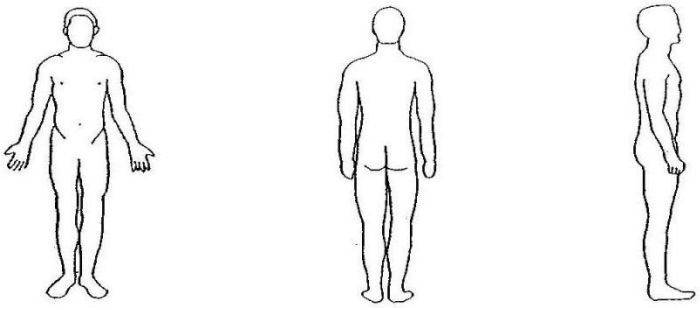
**What makes it better?**_____ **Worse?** _____

**You notice it during:** ☐ Sleeping ☐ Working ☐ Walking ☐ Sitting ☐ Standing ☐ Daily Activities

**What doctor(s) have you seen for this?**_____

**What does this keep you from doing?**_____

***Please circle areas of pain and injury.***
***Please be prepared to describe the type and quality of pain.***



*Please mark any of the following conditions that **currently** **or** have **previously** affected you:*

**GENERAL**

- ☐ CHRONIC FATIGUE
- ☐ TOBACCO USE
- ☐ ALCOHOL USE
- ☐ CANCER
- ☐ DIZZINESS

**NEUROLOGICAL**

- ☐ RINGING OF THE EARS
- ☐ HEADACHES
- ☐ MIGRAINES
- ☐ ARTHIRITS
- ☐ LEG/FOOT NUMBNESS
- ☐ SEIZURES

**MUSCULOSKELETAL**

- ☐ MUSCLE ACHES
- ☐ TROUBLE WALKING
- ☐ JOINT STIFFNESS
- ☐ MUSCLE WEAKNESS
- ☐ OSTEOPOROSIS
- ☐ JOINT REPLACEMENT

*PLEASE IDENTIFY CURRENT MUSCULOSKELETAL ISSUES ON PREVIOUS BODY PICTURES*

**RESPIRATORY**

- ☐ SHORTNESS OF BREATH
- ☐ ASTHMA
- ☐ PNEUMONIA
- ☐ EMPHYSEMA

**GASTRO-INTESTINAL**

- ☐ DIARRHEA
- ☐ CHRON'S DISEASE
- ☐ DIGESTIVE ISSUES
- ☐ CONSTIPATION
- ☐ GALLBLADDER ISSUES
- ☐ LIVER PROBLEMS

**ENDOCRINE**

- ☐ HOT FLASHES
- ☐ HAIR LOSS
- ☐ TYPE 1 DIABETES
- ☐ TYPE 2 DIABETES
- ☐ MENSTRUAL ISSUES
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM

**MENTAL**

- ☐ ANXIETY
- ☐ DEPRESSION

**EARS, EYES, NOSE, THROAT**

- ☐ ALLERGIES
- ☐ THROAT ISSUE
- ☐ EAR PROBLEM
- ☐ NOSE PROBLEM
- ☐ EYE PROBLEM

**GENITO-URINARY**

- ☐ URINARY ISSUES
- ☐ KIDNEY ISSUES
- ☐ KIDNEY STONES
- ☐ BED WETTING
- ☐ PROSTATE PROBLEM

**CARDIOVASCULAR**

- ☐ EASILY BRUISED
- ☐ POOR CIRCULATION
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ HIGH CHOLESTEROL
- ☐ STROKE
- ☐ PACEMAKER

**Other:**_____

_____

**Current Medications:**

Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____
Medication:_____ Reason for taking:_____

**Date of last medical exam:**_____ ☐ Unknown

## *Past History*

**Doctors you're currently seeing:**_____

_____

**Past auto accidents:**_____ **Was care received?**_____

**Past work injury:**_____ **Was care received?**_____

**Significate trauma [falls, etc.]:**_____

_____

**Any hospitalizations and/or surgeries:**_____

_____

## *Family History*

**Mother's side:** ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Arthritis

**Other:**_____

**Father's side:** ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Arthritis

**Other:**_____

**Other relevant family history:**_____

## *Lifestyle*

**Do you regularly drink coffee:** ☐ No ☐ Yes **How many cups per day?**_____

**Do you regularly drink soda:** ☐ No ☐ Yes **How many cans per day?**_____

**Do you regularly drink water:** ☐ No ☐ Yes **How many bottles per day?**_____

**How many days per week do you exercise?** ☐ None ☐ 1-2 days ☐ 3-4 days ☐ 5-6 days ☐ 7 days

**Any current hobbies?**_____

**How would you rate your diet?** ☐ Excellent ☐ Good ☐ Needs Improvement ☐ Don't get me started

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# INFORMED CONSENT TO CHIROPRACTIC CARE

## CHIROPRACTIC

It is important to acknowledge the difference between the health care specialist of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Physician's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

## ANALYSIS

A Chiropractic Physician conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmissions throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no physician can promise you specific results. This depends upon the inherent recuperative powers of the body.

## DIAGNOSIS

Although Chiropractic Physicians are experts in chiropractic diagnosis of VSS and VSC, they are not internal medical specialist. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he has any concerns as to the nature of his total condition. Your Chiropractic Physician may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

## INFORMED CONSENT TO TREAT

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The patient should look to the correct specialist for the proper diagnosis and clinical procedures. The Chiropractic Physician provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

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**RESULTS**

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC since there are so many variables. It is difficult to predict the time schedule or efficacy of Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond with Chiropractic, may come under the control or be helped through medical science. The fact us that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease. The patient should discuss any questions or problems with the doctor before signing this statement of policy. I have read the foregoing and understand it.

**Signature**: _____ **Date**: _____

**Print**: _____

**Phone**: _____

**Email**: _____

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**PATIENT ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES PURSUANT TO HIPPA AND CONSENT FOR USE OF HEALTH INFORMATION**

Name: _____ Date: _____
(Print Patient's Name)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPPAA and has been advised that a full copy of this office's HIPPAA compliance manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with Notice of Privacy Practices Pursuant To HIPPAA, the HIPPAA Compliance Manual, State law, and Federal law.

Dated this _____ day of _____, 20___

By _____
(Patient or Parent/Legal Guardian Signature)