EFC NEW PATIENT PAPERWORK

Today's Date: _ __ / ___ / ____

Patient Demographic

Legal Name: _____ Preferred Name: _____ Birth Date: ___ - ___ - ____

Age: ____ Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Mobile: (___) ____ - _____

Sex: M F Other Marital Status: Single Married Divorced Widow

Spouse's Name: _____ Number of Children: _____ Ages: _____

Occupation: _____ Employer: _____ How Long? _____

Who may we thank for referring you? _____

Have you ever had chiropractic care before? Y N if so Whom? _____ How long? _____

How long under care _____

Emergency contact (Name, Relation, number) _____

Current Problem

The reason for this visit is the result of (Please Circle): New Injury Chronic Auto Work Sports Other: _____

If accident related, has the injury been reported? Y N N/A To Whom: _____

Please identify the condition (s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth:_____

Please circle the number that best describes you pain level: 0= no pain 10= worst pain imaginable

Primary or chief complaint:	0	1	2	3	4	5	6	7	8	9	10
Secondary:	0	1	2	3	4	5	6	7	8	9	10
Third:	0	1	2	3	4	5	6	7	8	9	10
Fourth:	0	1	2	3	4	5	6	7	8	9	10

When did problem begin? _____ How did it happen? _____

When is the problem the worse? AM or PM What relieves your symptoms?_____

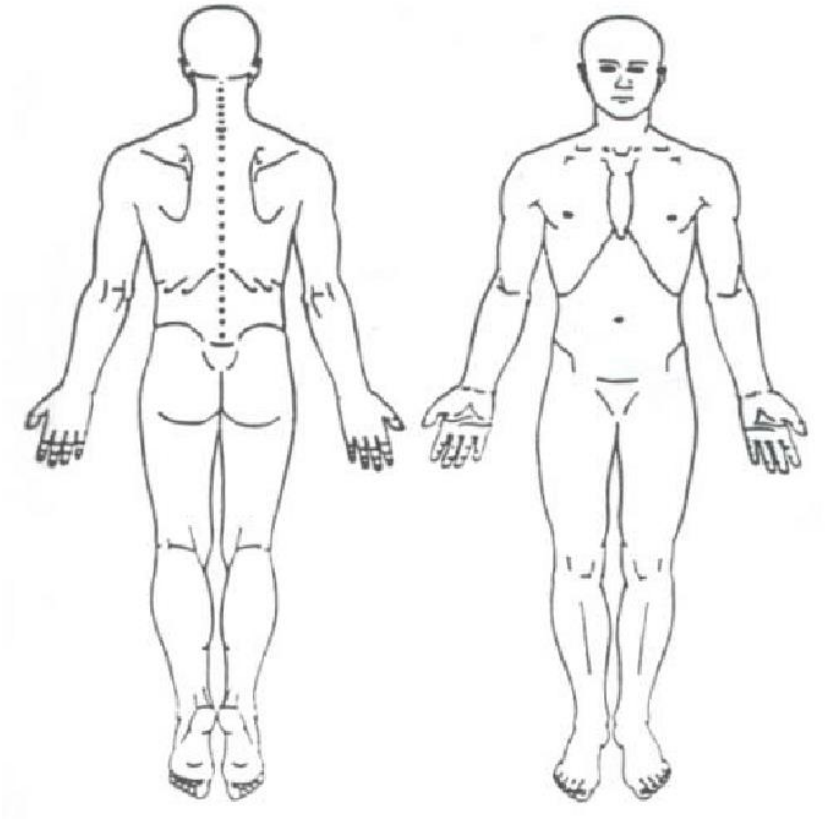
What makes it worse? _____ How long does it last? _____

Is it constant or experienced on and off? _____

Has this condition ever been treated by anyone else in past? If yes, when and by whom?

_____

Show us where it hurts



R= Radiating	**B= B**urning
D= Dull	**A= A**ching
N= Numbness	**S= S**harp/**S**tabbing
T= Tingling	

Health history

Please list any surgeries or hospitalizations with dates: _____

Please list any past serious accidents with dates: _____

Please list any current or past medical condition (s):_____

What medications are you taking?

Do you smoke? Y or N ___# of packs/day

Drink Alcohol? Y or N ___# of drinks a week

Do you exercise? Y or N How often?_____

Do you take supplements? Y or N Which ones? _____

Any family history of diabetes, stroke, heart disease or cancer?

Women only:

Pregnant? Y or N

Nursing? Y or N

Birth Control? Y or N

Date of last menstrual Cycle _____

Daily activities

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing computer work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform

Please mark P for in the Past, C for Currently have and N for Never

___Headache	___Pregnant (Now)	___Dizziness	___Prostate Problems	___Heartburn
___Neck Pain	___Frequent Colds/Flu	___Loss of Balance	___Digestive Problems	
___Jaw Pain, TMJ	___Convulsions/Epilepsy	___Fainting	___Colon Trouble	___High Blood Pressure
___Shoulder Pain	___Tremors	___Double Vision	___Diarrhea/Constipation	___Low Blood Pressure
___Upper Back Pain	___Chest Pain	___Blurred Vision	___Menopausal Problems	___Asthma
___Mid Back Pain	___Pain w/Cough/Sneeze	___Ringing in Ears	___Menstrual Problem	___Difficulty Breathing
___Low Back Pain	___Foot or Knee Pain	___Hearing Loss	___PMS	___Lung Problems
___Hip Pain	___Sinus/Drainage Problem	___Depression	___Bed Wetting	___Kidney Trouble
___Back Curvature	___Swollen/Painful Joints	___Irritable	___Learning Disability	___Gall Bladder Trouble
___Scoliosis	___Skin Problems	___Mood Changes	___Eating Disorder	___Liver Trouble
___Numb/Tingling arms, hands, fingers		___ADD/ADHD	___Trouble Sleeping	___Hepatitis (A, B, C)
___Impotence/Sexual Dysfunction		___Allergies	___Ulcers	

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly mutual understanding between provider and patient. Out policy requires payment in full at time of service, unless other arrangements have been made with the doctor. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release information required to process insurance claims.

I understand the above information and completed this form correctly to the best of my ability

_____ _____/_____/_____

Signature Date

_____

Printed Name

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable, depending on extent of condition.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, dislocations, strains, and sprains. In addition, the literature recognizes an association between strokes and chiropractic manipulation of the cervical spine. With respect to strokes, 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 a 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 dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Carotid and vertebral artery dissections are rare, with an annual incidence of 2.5 – 4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, 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 visits to a chiropractor or a primary care physician and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million visits.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. 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. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Parent or Guardian: _____ Signature:_____ Date:_____

Witness Name: _____ Signature:_____ Date:_____

REGARDING: X-ray/Imaging Studies

FEMALES ONLY: Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see out receptionist for further explanation.

The first day of my last menstrual cycle was on ____/____/_____

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____/_____/_____ _____ Witness Initials

Patient or Authorized person's Signature Date

_____

Printed Name