

**NEW PATIENT INFORMATION**  
**Welcome!**

Please allow our staff to photocopy your driver's license and Insurance card (if applicable)

**PLEASE PRINT CLEARLY** Full Name \_\_\_\_\_

Email \_\_\_\_\_ Gender M F Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_

Marital Status (circle) S M D W # of children \_\_\_\_\_ Work Status (circle) Full-time Part-time Retired

Females: Last Menstrual Period \_\_\_\_\_ Pregnant? Y N Nursing? Y N Fax Number (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation \_\_\_\_\_ Wk Phone (\_\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ zip \_\_\_\_\_

Name of Spouse, Parent or Guardian \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_ Wk Phone \_\_\_\_\_

In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Wk Phone (\_\_\_\_\_) \_\_\_\_\_

Do you have Health Insurance? Y N Plan/Group# \_\_\_\_\_ Insurance Card Copied by Staff Y N

Driver's license copied by Office Y N

How did you hear about our office? Whom may we thank for referring you \_\_\_\_\_

**Allergies:** Please check and list all allergies.

\_\_\_ Food: \_\_\_\_\_

\_\_\_ Medications: \_\_\_\_\_

\_\_\_ Seasonal / Other: \_\_\_\_\_

**MEDICATIONS:** Please list all medications that you are currently taking.

**SCARS/SURGICAL PROCEDURES:** List all scars and surgical procedures you have had \_\_\_\_\_

**Supplements:** Do you take Vitamins/supplements or Herbs? \_\_Y \_\_N If yes, who recommended them? \_\_\_\_\_

**Check**

**Habits:**

	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Soda/Diet Soda	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Stress Level	_____	_____	_____	_____

**Circle:**

Exercise	5-7x/wk	3-5x/wk	1-3/xwk	None	Type _____
Sleep	8+ hrs	7-8 hrs	6-7 hrs	< 5 hrs	
Meals / Day	5+	4	3	2	
Water / day	64+ oz	23-63 oz	16-32 oz	<8 oz	

**Work Activity:** (circle) Heavy Labor Light Labor Mostly sitting Mostly standing Walking/ Moving Driving

**Family History:** Identify any conditions that you, or any of your family members have now or have had in the past:  
 (G = Grandparents, M = Mother, F = Father, S = Siblings, X = Self)

- |   |                                    |  |                                       |
|---|------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Miscarriage(s)  | <input type="checkbox"/> Tumor(s)     |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Ulcer(s)     |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cold sores           | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Pneumonia       | _____                                 |
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Goiter    | <input type="checkbox"/> Polio           | _____                                 |
| <input type="checkbox"/> Detached retina      | <input type="checkbox"/> Gout      | <input type="checkbox"/> Rheumatic fever |                                       |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Stroke          |                                       |

**Health Concerns:** Please list your top health concerns in order of priority.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Treatment:** What type of treatment are you looking for?

- I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.  
 I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.  
 I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

**Complain/Problem:** In relation to your primary complaint: **When did problem begin?** \_\_\_\_\_

When did you first seek treatment for this problem? \_\_\_\_\_ Has another doctor(s) treated you for this condition Y N

If yes, when \_\_\_\_\_ Treatments \_\_\_\_\_

Have you had any intolerance or reactions to treatments? Y N Describe: \_\_\_\_\_

If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_

**How did it originally occur?** \_\_\_\_\_ Has it become worse recently? Y N Same Better Gradually Worse

How frequent is the condition? Constant Daily Intermittent Night only How long does it last? All day Few hours Minutes

Is this condition interfering with your (circle all that apply) Work Sleep Daily routine Recreation Other \_\_\_\_\_

How long has it been since you really felt good? Days Weeks Months Years >10 years

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other \_\_\_\_\_

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other \_\_\_\_\_

Is there anything that you can do to relieve the problem? Y N If yes, describe \_\_\_\_\_

If no, what have you tried to do that has not helped? \_\_\_\_\_

What do you believe is wrong with you? \_\_\_\_\_

Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? \_\_\_\_\_

**Have you been in an auto accident?** (Circle) Past year Past 5 years Over 5 years Never

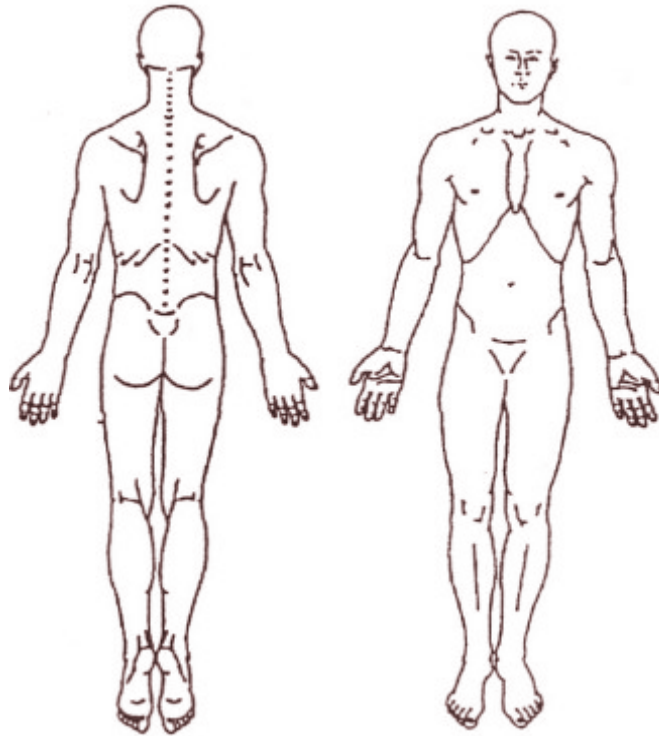
Describe \_\_\_\_\_

Please mark all of the symptoms that apply with a P or C (P = Past / C=Current)

- | P/C  | P/C   | P/C  |                                      |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Nausea/Vomiting    | <input type="checkbox"/> Weak Muscles      | <input type="checkbox"/> Dizziness   |
| <input type="checkbox"/> Earache             | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Insomnia          | <input type="checkbox"/> Sinusitis   |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Teeth Grinding    | <input type="checkbox"/> Fatigue     |
| <input type="checkbox"/> Excessive Thirst    | <input type="checkbox"/> Elbow/Hand Pain    | <input type="checkbox"/> Tingling in Hands | <input type="checkbox"/> Neck Pain   |
| <input type="checkbox"/> Clammy Hands        | <input type="checkbox"/> Low Back Pain      | <input type="checkbox"/> Hip Pain          | <input type="checkbox"/> Knee Pain   |
| <input type="checkbox"/> Shoulder Pain       | <input type="checkbox"/> Swollen Joints     | <input type="checkbox"/> Joint Stiffness   | <input type="checkbox"/> Headache    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ankle/Foot Pain   | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Sore Muscles       | <input type="checkbox"/> Tingling in Feet  | <input type="checkbox"/> Eye Pain    |
| <input type="checkbox"/> Other: _____        |   |  |                                      |

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

- |                        |                |
|------------------------|----------------|
| Stabbing/Cutting – III | Tingling - ::: |
| Burning – XXX          | Cramping - ^^  |
| Numbness - ===         | Dull - ###     |



Notes:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow AZ Choice Chiropractic to use their PHI for the purpose of treatment, payment, health care operations, in-house marketing, reminder of appointments, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/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 effect 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 Arizona's Choice Chiropractic 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, the chiropractic physician has the right to refuse to give care.

**AUTORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT**

To: Arizona's Choice Chiropractic Doctors, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a scheduled massage appointment 24 hours in advance of the appointment I may be charged a \$25.00 cancellation fee.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.
7. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
8. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.
9. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) I seek treatment.
10. A photocopy of this form shall be as valid as original

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

\_\_\_\_\_  
 Patient's signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Legal guardian if patient is a minor

\_\_\_\_\_  
 Relationship to minor