WELCOME!

NEW PATIENT APPLICATION & HISTORY

1. PATIENT INFORMATION

Patient Name_____

What you prefer to be called:_____

Date_____ SS#:_____

E-mail_____

Address_____

City_____

State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birth date:_____

☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐Other

Employer_____ Phone: (____)_____

Occupation_____

Spouse's Name_____

Who referred you? _____

Name of family physician_____

May we contact them regarding your health? ☐ Yes ☐ No

Have you ever received chiropractic before? ☐ Yes ☐ No

If yes, who was your chiropractor? _____

What kind of results did you have? _____

PATIENT PHONE NUMBERS:

Home (_____)_____

Cell (_____)_____

Work (_____)_____

EMERGENCY CONTACT NUMBERS:

Name_____

Relationship_____

Home (_____)_____

Cell (_____)_____

Work (_____)_____

2. Financial/INSURANCE INFORMATION

Who is responsible for this account? (☐ Self) _____

Relationship to patient_____

ASSIGNMENT, RELEASE and PAYMENT POLICY

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Gregory S. Manning all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

Co-insurance/co-pay amounts are to be collected at the time services are received. We accept cash, personal check, VISA, Mastercard, and Discover. All medical services provided are directly charged to the patient. Our office will bill the responsible party/insurance carrier on behalf of the patient.

If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed to be patient responsibility, not medically necessary, or non-covered charges by your insurance carrier.

Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. We will extend a 90-day period for your insurance carrier to process claims and issue any payments due. If after 90 days your carrier fails to issue expected payment, all charges due will become member responsibility and billed accordingly.

Signature of Patient (or Guardian)_____

Print Patient Name (or Guardian)_____

Relationship to Patient_____ Date:_____

3. ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Yes ☐ No

Date:_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Have you made a report of your accident? ☐ Yes ☐ No

To Whom? ☐ Auto Insurance ☐ Employer ☐ Workers' Comp

☐ Other _____

Attorney Name (if applicable)_____

4. PATIENT CONDITION and CASE HISTORY

Name:_____ Date:_____

Reason for visit_____

When did your symptoms start? _____ How did your problem start?_____

Rate your pain level:

0 1 2 3 4 5 6 7 8 9 10

No Pain ***Severe Pain***

Is your pain? ☐ Daily ☐ Intermittent _____ X per week **AND IS IT**
☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent
(100% of day) (75% of day) (50% of day) (25% of day)

Describe the pain:
☐ Sharp ☐ Dull ache ☐ Shooting ☐ Burning ☐ Radiating ☐ Throbbing ☐ Stabbing ☐ Numbness ☐ Tingling ☐Other

Is your condition?
☐ Getting Better ☐ Staying the same ☐ Getting Worse

Does it interfere with?
☐Work ☐Sleep ☐Recreation ☐Daily Activity ☐Nothing

What are you having trouble doing?
_____

What makes you worse?
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down ☐ Movement ☐ Twisting ☐ Lifting ☐ Sleeping

What makes you better?
☐Nothing ☐Rest ☐Activity ☐Heat ☐Cold ☐Medication

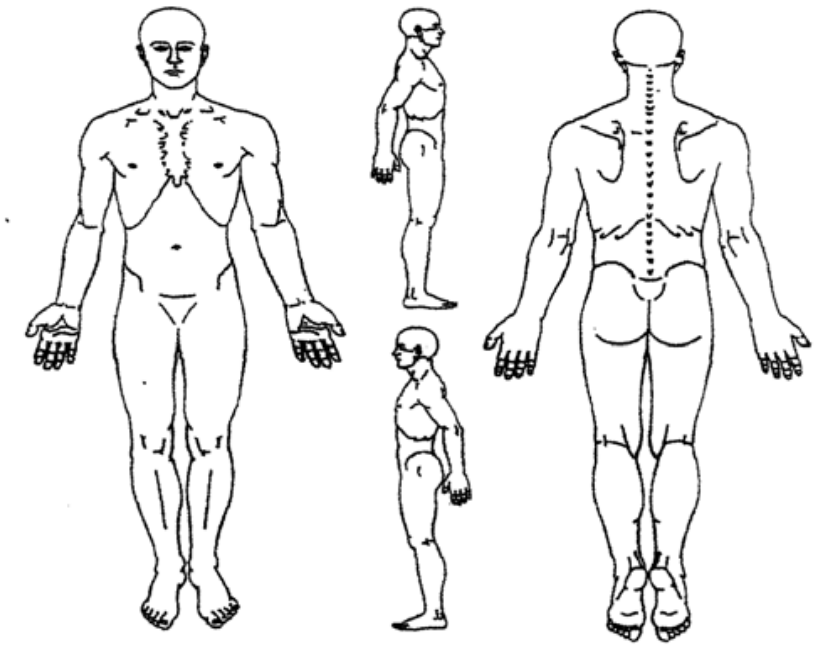
What tests have you had?
☐X-rays ☐MRI ☐EMG ☐Ultrasound ☐Lab work ☐ _____ If so, where? _____

What treatment have you had?
☐Drugs ☐Nerve blocks ☐PT ☐Surgery ☐ None ☐ Other _____

Has the treatment helped? ☐Yes ☐No

Have you ever had this problem before? ☐Yes ☐No How long ago? _____

(Please mark your areas of pain)



I certify that the above information is accurate to the best of my knowledge. Patient/Guardian Signature _____ Date _____

PATIENT NAME: _____

5. SOCIAL HISTORY

Exercise Activity	Work Activity	Use of Tobacco	Use of Alcohol	Stress Level
☐ None	☐ Sitting	☐ Never	☐ Never	☐ Low
☐ Light	☐ Standing	☐ Previously, but quit	☐ Rarely	☐ Moderate
☐ Moderate	☐ Light labor	☐ Currently	☐ Moderate	☐ High
☐ Strenuous	☐ Heavy labor	_____ Packs per day	☐ Daily	Reason_____

6. PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you*

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling
- ☐ Tremors
- ☐ Stroke

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Joint Replacement _____

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Pacemaker

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Blood in stools
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Ulcers

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ Memory loss

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes
- ☐ Thyroid disorder

Integumentary (skin, breast)
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Breast pain or lump
- ☐ Dermatitis / Eczema

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus
- ☐ Cancer
- ☐ HIV/AIDS

Are you Pregnant?
- ☐ No
- ☐ Yes Due Date_____

7. FAMILY HISTORY

	Living?		Rheumatoid Arth		Cancer		Diabetes		Heart Problems		Back Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. LIST INJURIES, HOSPITALIZATIONS, SURGERIES, OR OTHER TREATMENTS

Falls_____

Fractures _____

Hospitalizations/Surgeries_____

Other Treatments_____

9. MEDICATIONS / SUPPLEMENTS / ALLERGIES

MEDICATIONS	SUPPLEMENTS	ALLERGIES
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

_____ _____ **Reviewed by:** _____

Signature of Patient or Parent of Minor **Date**

10. Informed Consent For Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications which may arise during treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of my treatment for my present condition(s) and for future condition(s) for which I seek treatment.

CONSENT FOR TREATMENT OF MINOR (if applicable):
I hereby authorize Dr. Gregory S. Manning and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient

X_____ _____

Signature of Patient, Parent or Guardian **Date**

X_____ _____

Signature of Witness **Date**

11. Receipt of Privacy Notice

My signature, below, certifies that I have had a copy of the NOTICE OF PRIVACY PRACTICES made available to me.

X_____ _____

Signature of Patient or Representative **Date**