Application For Care

Welcome to New Hope Chiropractic! Thank you for taking a moment to fill in our Application For Care form. Please fill out this form completely and to the best of your knowledge. Let our staff know if you have any questions. When complete return it to our office with the bottom authorizations checked and appropriate signature filled in.

Patient information:

First Name: _____ Middle: _____ Last name: _____

Date of Birth: _____ Sex: M F Height: _____ Weight: _____ Blood Pressure: _____/_____

Married/Civil Union: ☐Married ☐Single Spouses Name:_____ # of Children:_____

Home Phone #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail:_____

Insurance information: (Please give your card to the receptionist)

Will you be filing insurance for your chiropractic visits? Y N

Employer information:

Employed: ☐Full Time ☐Part Time ☐Homemaker ☐Unemployed

Occupation:_____

Employer Name:_____

Employer Address:_____

_____

History:

Current Prescription Medications: (name, amounts, frequency, length of use, reason for use)

_____

_____

Current Vitamins, Minerals, Supplements, or Herbs: (name, amounts, frequency, length of use, reason for use)

_____

_____

Medication Allergies: (name, reaction, onset date)

_____

_____

Women only: Are you pregnant? Y N Due Date:_____

Have you ever:

Broken Bones: Y N Treatment: Y N Explain: _____

Sprains/Strains: Y N Treatment: Y N Explain: _____

Hospitalized: Y N Explain: _____

Surgery: Y N Explain: _____

Auto Accidents: Y N Treatment: Y N Explain: _____

Struck Unconscious: Y N Treatment: Y N Explain: _____

Stroke: Y N Explain: _____

Family Health History: (example: arthritis, cancer, diabetes, heart disease, kidney disease, etc.)

_____

_____

Social history & life choices:

Alcohol: ☐Daily ☐Weekly ☐Occasionally ☐Never

Water: ☐Daily ☐Weekly ☐Occasionally ☐Never

Caffeine Drinks: ☐Daily ☐Weekly ☐Occasionally ☐Never

Drugs: ☐Daily ☐Weekly ☐Occasionally ☐Never

Exercise: ☐Daily ☐Weekly ☐Occasionally ☐Never

Tobacco: ☐Daily ☐Weekly ☐Occasionally ☐Never

Chiropractic experience:

Who referred you to our office? _____

How did you find our office? ☐Sign ☐ Online ☐Insurance Co.

Have you been adjusted by a chiropractor before? Y N

If yes, what was the reason? _____

Doctor's name: _____ Date of lase visit: _____

Has any member of your family ever seen a chiropractor? Y N

Reason for visit:

Describe the reason for this visit: _____

When did this concern begin? _____

Does this concern interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Other Activities

Has this concern occurred before? Y N Explain: _____

Have you seen other doctors for this concern? Y N Doctor's Name: _____

Type of treatment: _____

Goals for your care:

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the doctor to select the type of care appropriate for my condition.

☐ Relief care: symptomatic relief of pain or discomfort.

☐ Corrective Care: Correcting and relieving the cause of the problem as well as the symptoms.

☐ Comprehensive Care: Bring whatever is malfunctioning in the body to the state of health possible with chiropractic care.

Do you know what a subluxation is? Y N

Were you aware that...

Doctors of Chiropractic work with the nervous system? Y N
The nervous system controls all bodily functions and systems? Y N
Chiropractic is the largest natural healing profession in the world? Y N

Authorization:

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submission. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

☐ **I agree with this statement of authorization.**

☐ **I choose to decline receipt of my clinical summary after every visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient/ Guardian's Signature: _____ **Date:** _____