RH SPINAL CARE

NEW PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____

Street City State Zip Code

E-mail: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Age:_____

Occupation: _____ Employer: _____

Name of Emergency Contact: _____

Phone #: _____ Relationship to Patient: _____

Where you recently injured in a car crash or at work? Yes or No

We take a personalized approach to helping you restore your health, recover from injuries, and achieve optimal living. To better understand your concerns and unique background, please share up to 3 health concerns that you hope to address by partnering with RH.

1. _____
2. _____
3. _____

Have you previously tried any of the following? Chiropractors, Physical Therapists, Medical Doctors or Other Providers for any of the above? Yes No

Do you have any of the following symptoms or health struggles? Check all that apply:

- ❑ Headaches or Migraines
- ❑ Shoulder, Elbow or Wrist Pain
- ❑ Hip, Knee or Ankle Pain
- ❑ Stomach or Digestive Issues
- ❑ Constipation or Diarrhea
- ❑ Sleep Issues or Fatigue
- ❑ Anxiety / Depression
- ❑ Hormone Issues
- ❑ Inflammation

❑ Please list any other health concerns you have and would like to discuss_____

_____

How did you hear about us? _____

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Please list any past injuries, sport injuries, hospitalizations, surgeries, broken bones, accidents/falls, and the date involved. _____

_____

Are you currently taking any prescription medication? Yes No

If yes, what for? _____

Are you currently taking any non-prescription medication? Yes No

If yes, what types and how much? _____

NOTICE OF PRIVACY PRACTICE SUMMARY

Our office uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive. Our office may use your information to provide appointment reminders, information about your treatment alternatives or other health related issues.

Our office must maintain the privacy of protected health information , provided you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to requested restriction on how your information is to be used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain written authorization to use or disclose health information for reasons other than those listed above and permitted under law.

AUTHORIZATION FOR TREATMENT & TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. 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, disc injuries, strokes, dislocations and sprains.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, 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) for which I seek treatment.

To the best of my knowledge I am NOT pregnant, and the doctor has my permission to x-ray me for diagnostic interpretation.

_____

Patient Name Patient Signature Today's Date