

Welcome to New Life Chiropractic & Vilulu!

NEW PATIENT INTAKE

Today's Date: _____ FULL NAME: _____ Male: _____ Female: _____

Preferred Name: _____ Birth Date: _____ Age: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home Phone: () _____ Cell () _____ Work () _____

How would you like to receive appointment reminders? () Email () Text Cell Phone Carrier _____

Occupation: _____ Employer Name: _____ Health Insurance: Yes No (circle one)

Single _____ Married _____ Spouse's Name _____ How Many Kids Do You Have? _____

Emergency Contact Name: _____ Phone Number _____

Whom may we thank for referring you to our office? _____

Are you seeing the Doctor today due to a Work or Auto Accident Related Injury? Yes_ No_ Date of Injury _____

YOUR HEALTH SUMMARY

PLEASE CHECK ALL SYMPTOMS YOU HAVE EVER HAD AND RATE THEM ON A SCALE OF 1-10 WITH 10 BEING THE WORST, EVEN IF THEY DO NOT

SEEM RELATED TO YOUR CURRENT PROBLEM:

- | | | |
|---|---|---|
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Fever _____ |
| <input type="checkbox"/> Pins and Needles in arms _____ | <input type="checkbox"/> Stiff Neck _____ | <input type="checkbox"/> Problem urinating _____ |
| <input type="checkbox"/> Dizziness _____ | <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Menstrual irregularity _____ |
| <input type="checkbox"/> Numbness in fingers _____ | <input type="checkbox"/> Lights bother eyes _____ | <input type="checkbox"/> Neck Pain _____ |
| <input type="checkbox"/> Fatigue _____ | <input type="checkbox"/> Menstrual Pain _____ | <input type="checkbox"/> Loss of balance _____ |
| <input type="checkbox"/> Sleeping problems _____ | <input type="checkbox"/> Weight gain _____ | <input type="checkbox"/> Nervousness _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Upset stomach _____ |
| <input type="checkbox"/> Cold sweats _____ | <input type="checkbox"/> Upper Back Pain _____ | <input type="checkbox"/> Tension _____ |
| <input type="checkbox"/> Mood swings _____ | <input type="checkbox"/> Mid Back Pain _____ | <input type="checkbox"/> Cold feet _____ |
| <input type="checkbox"/> Hormone problems _____ | <input type="checkbox"/> Low Back Pain _____ | <input type="checkbox"/> Hot flashes _____ |
| <input type="checkbox"/> Pins and Needles in legs _____ | <input type="checkbox"/> Ringing in ears _____ | <input type="checkbox"/> Heartburn _____ |
| <input type="checkbox"/> Loss of smell _____ | <input type="checkbox"/> Loss of taste _____ | <input type="checkbox"/> Adrenals _____ |
| <input type="checkbox"/> Buzzing in ears _____ | <input type="checkbox"/> Irritability _____ | <input type="checkbox"/> Thyroid _____ |
| | <input type="checkbox"/> Cold hands _____ | <input type="checkbox"/> Numbness in toes _____ |

List any medications you are taking and what they are for: _____

New Life Chiropractic & Vilulu conforms to the current HIPPA guidelines. You may request a copy of our HIPPA Policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____



TERMS OF ACCEPTANCE

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease other than the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor. I understand that New Life Chiropractic and/or Vilulu will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made. In the event of non-payment, it is agreed that I will be responsible for all costs of collections including collection agency fees of 25.0% of the amount owed and/or any related court costs/attorney's fees.

I _____ have read and fully understand the above statements.
(Print Name)

Signature: _____ **Date:** _____

CONSENT TO EVALUATE AND ADJUST A MINOR

I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. If you agree, sign below:

Signature: _____ **Date:** _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and the doctors at New Life Chiropractic, Vilulu and the staff have my permission to perform X-rays. I have been advised that an X-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

Signature: _____ **Date:** _____