NEW LIFE CHIROPRACTIC CENTER

Phone: 260-471-LIFE (5433)
Fax: 260-471-5413
support@newlifechiro.net

New Patient Intake Form

Please Fill Out This Form in Its Entirety

Thank you for your trust and for giving New Life Chiropractic the opportunity to help. It is our pleasure to greet you and likewise our honor to serve you.

Our desire is to determine how we might be of the greatest help to you while doing our best to aid you with your health and healing needs.

Please be advised that this office is **NOT** like most other Chiropractic offices, in that we are one of only a few that specialize in the type of care that we provide.

We continually receive high praise from our patients because we take the time to search for the underlying cause of any given condition while delivering the highest level of care possible. It is our belief that when both parties agree and commit to excellence, the optimum results are achieved.

Because our office is highly specialized in our approach to improved neurological adaptation, function and health, it is important that you understand a few things about us.

- Care will begin only after each patient has been properly examined, and care recommendations have been determined, reviewed and agreed upon.
- Our New Patient Examination fee is $147 and will include all necessary diagnostic testing that our doctor(s) determine is needed, which may include the examination, neurological testing, and/or x-rays. **THIS IS OUR TIME OF SERVICE DISCOUNTED** cash fee and insurance will NOT be billed.
- We have intentionally chosen to remain OUT of ALL Insurance Networks, including being a Medicare ***'Non-Participating'*** Provider. We also **DO NOT TAKE MEDICAID.**
- Medicare Beneficiaries: the Medicare Benefit Policy Manual states in Chapter 15, Section 240, that maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. Medicare only pays for acute treatment.
- We offer cash discounts, payment plans, family discounts, and case fees which allow our patients to receive the care that they need. Many patients also find Care Credit (third-party) interest-free financing helpful when it is approved.
- We **DO NOT** accept all patients. We only accept patients who our doctor(s) feel we can help, and who have agreed to follow all terms relating to care recommendations.

Name: _____ Signature: _____ Date: _____

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Today's Date: ____/____/_____ Full Name: _____ Preferred Name: _____

Gender: ☐ Male ☐ Female Birthdate: ____/____/_____ Age: _____ Social Security #: _____-_____-_____

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

Email: _____ Phone: (_____) _____-_____ Does this phone accept texts: ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____ Spouse's Name: _____

How Many Children: _____ Occupation: _____ Employer's Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about us? ☒Family/ Friend ☐Google ☐Facebook ☐Radio ☐Paper ☐Healthcare Practitioner

☐Other: _____ If Family/ Friend / Healthcare Practitioner, Who? _____

Chief Complaint:

What are you most needing help with? _____

Is this the first occurrence or have you experienced this before? _____

When was the first time EVER that you recall experiencing this? _____

On a pain scale of 1-10, with 10 as WORST, how would you currently rate your pain? 1 2 3 4 5 6 7 8 9 10

At it's WORST, on a pain scale of 1-10, how bad has it gotten? 1 2 3 4 5 6 7 8 9 10

To feel like you could carry on normally, what would the pain have to get to? 1 2 3 4 5 6 7 8 9 10

Frequency - since the onset, how often does your pain occur?
☐Constant ☐ Off/On ☐ At Rest ☐ With Activity ☐Other: _____

Duration - since the onset, how long does your pain occur?
☐ Doesn't last as long ☐ Lasting longer ☐ Same as initially ☐ Other: _____

Intensity - since the onset, how has the intensity of pain been?
☐ Has become less intense ☐ Same as initially ☐ Has become more intense ☐ Other: _____

At what time of day is the pain worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During sleep ☐ Other: _____

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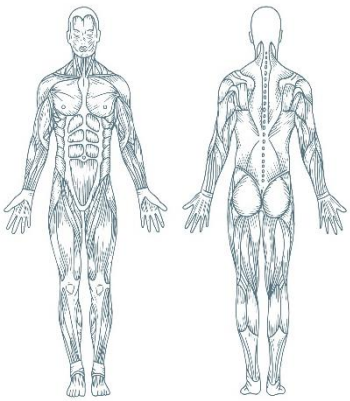
Please mark the area(s) of pain/discomfort
On diagram below



Is there anything that you have found that creates or increases pain? ☐ Yes ☐ No
-if 'Yes', what? _____

What have you tried to do in an effort to find relief? ☐ MD ☐ PT ☐ Meds ☐ Massage
☐ Home remedies ☐ Chiropractic ☐ Other: _____

Have you found anything that has helped alleviate the pain? ☐ Yes ☐ No
-if 'Yes', what? _____

Have you ever been under chiropractic care? ☐ Yes ☐ No
-if 'Yes', how long since your last visit? _____

At its worst, how does the pain make you feel? _____

Does the pain radiate? ☐ Yes ☐ No -if 'Yes', please describe: _____

How has the pain negatively impacted your family life? _____

How has the pain negatively impacted your work life? _____

How has the pain negatively impacted your recreational/hobby life? _____

If you woke tomorrow and you were completely free from any pain and/or discomfort, what would be different? _____

_____

Are you currently being treated for any other health conditions/struggles? ☐ Yes ☐ No
-if 'Yes', what? _____

Are you currently taking any prescription medications? ☐ Yes ☐ No -if 'Yes', what? _____

_____

Are you currently taking any over-the-counter medications? ☐ Yes ☐ No -if 'Yes', what? _____

_____

Has your doctor recommended that you lose weight? ☐ Yes ☐ No

How would you describe your typical diet? _____

Do you exercise regularly? ☐ Yes ☐ No How would you best describe your activity level? _____

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Rest is important. How would you best describe your time at rest? _____

In what position do you most commonly wake? ☐ Back ☐ Side ☐ Stomach ☐ Other: _____

Have you ever been involved in an accident (automobile, work, falls, sports, etc)? ☐ Yes ☐ No
-if 'Yes', please describe: _____

_____

What activity/activities do you perform most commonly each day (PC work, lifting, sitting, climbing ladders, etc)? _____

_____

How much time each day do you spend performing the previously noted activities? _____

Head (mark all that apply):

☐ Temple pain ☐ Forehead pain ☐ Top of head pain ☐ Eye pain ☐ Entire head pain
☐ Base of skull pain ☐ Dizziness ☐ Fainting ☐ Lightheaded ☐ Ear pain
☐ Ringing in ears ☐ N/A ☐ Other: _____

Neck (mark all that apply):

☐ Muscle spasms ☐ Pain when turn head ☐ Pain with side-to-side ☐ Stiffness ☐ Grinding sound/feeling
☐ Diagnosed w/ bone spurs ☐ Disc degeneration ☐ Neck surgery ☐ Fractures ☐ Cortisone shot in neck
☐ N/A ☐ Other: _____

Shoulders (mark all that apply):

☐ Pain in shoulder(s) ☐ Front shoulder pain ☐ Back shoulder pain
☐ Bursitis ☐ Arthritis ☐ Side shoulder pain
☐ Can't raise arm past 90 degrees ☐ Can't place hand in back pocket ☐ Can't raise arm above head
☐ Cortisone shot in shoulder ☐ N/A ☐ Other: _____

Arms/Hands (mark all that apply):

☐ Pain in upper arm ☐ Pain in forearm ☐ Pain in wrist ☐ Pain in fingers
☐ Pins/needles in hand ☐ Pins/needles in arm ☐ Finger go to sleep ☐ Hand cold
☐ Swollen joints in fingers ☐ Sore joints in fingers ☐ Arthritis ☐ Loss of grip strength
☐ Cortisone shot in arm/wrist/hand ☐ N/A ☐ Other: _____

Mid Back (mark all that apply):

☐ Mid-back pain ☐ Pain btw shoulders ☐ Pain up/down back ☐ Pain across back
☐ Pain with breathing ☐ Cortisone shot ☐ N/A ☐ Other: _____

Lower Back (mark all that apply):

☐ Lower back pain ☐ Pain when standing ☐ Pain when sitting ☐ Pain when bending
☐ Pain when walking ☐ Pain up/down back ☐ Pain across lower back ☐ Disc problems
☐ Cortisone Shot ☐ N/A ☐ Other: _____

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Hip(s) (mark all that apply):

- ☐ Pain in buttocks
- ☐ Pain when standing
- ☐ Pain when sitting
- ☐ Pain on side of hip
- ☐ Pain in tailbone
- ☐ Bursitis in hip(s)
- ☐ Arthritis in hip(s)
- ☐ Cortisone shot in hip(s)
- ☐ N/A
- ☐ Other: _____

Legs/Feet (mark all that apply):

- ☐ Pain down right leg
- ☐ Pain down left leg
- ☐ Leg cramps
- ☐ Pins/needles in right leg
- ☐ Pins/needles in left leg
- ☐ Numbness in right leg
- ☐ Numbness in left leg
- ☐ Numbness in right foot
- ☐ Numbness in left foot
- ☐ Numbness in toes
- ☐ Feet feel cold
- ☐ Cramps in right foot
- ☐ Cramps in left foot
- ☐ Swollen right ankle
- ☐ Swollen left ankle
- ☐ Pain in right knee
- ☐ Pain in left knee
- ☐ Pain in right ankle
- ☐ Pain in left ankle
- ☐ Pain in right foot
- ☐ Pain in left foot
- ☐ Leg surgery
- ☐ Knee surgery
- ☐ Ankle surgery
- ☐ Foot surgery
- ☐ Arthritis
- ☐ Cortisone shot in knee
- ☐ Cortisone shot in foot/ankle
- ☐ N/A
- ☐ Other: _____

Consent to evaluate and treat a minor:

I _____ being the parent or legal guardian of _____ have read and agree to the attached informed consent and hereby grant permission for my child to receive chiropractic care.

Name: _____ Signature: _____ Date: _____

Pregnancy release:

This is to certify that to the best of my knowledge; I am not pregnant and thereby authorize New Life Chiropractic and our doctors/x-ray technicians to take any recommended and necessary x-rays. I have been advised that x-ray can be hazardous to an unborn child.

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Family Health History

Please Check All That Apply

Condition	Self	Mother	Father	Siblings	Spouse	Children	None
Allergies	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bursitis	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐
Cramps	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Gallbladder	☐	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Lower Back Pain	☐	☐	☐	☐	☐	☐	☐
Mid Back Pain	☐	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐	☐
MS	☐	☐	☐	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐	☐	☐	☐
Nervousness	☐	☐	☐	☐	☐	☐	☐
Neuritis	☐	☐	☐	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐	☐	☐	☐
Ringing in Ears	☐	☐	☐	☐	☐	☐	☐
Sinus Problems	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

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Informed Consent to Care

You are the decision-maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as *"informed consent"* and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joints, and improving neurological functioning and overall well-being.

It is important that you understand that, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, as well as fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an *"arterial dissection"* that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not.

Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, the percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related to between one in one million to one in two million cervical adjustments. By comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract is 1,219 events / per one million persons/year and risk of death has been estimated as 104 per one million users.

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It is also important that you understand that there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

For the purposes of our practice, and for this consent form, we adhere to the following definitions:

Health: a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 movable vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis of or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic findings, we will advise you appropriately. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in the area concerned.

Regardless of what the other disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice is to eliminate a major interference to the expression of the body's innate wisdom.

Should any insurance or 3rd party payor be involved, I authorize the staff at New Life Chiropractic, P.C. to perform any necessary services needed during diagnosis (of subluxation) and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims (such as those involved in an automobile-related injury).

I understand the above information and the guarantee of this form was completed correctly to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my health/medical status.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

The fee paid for the treatment of any x-rays is for analysis only. The x-rays themselves are the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary, at the patient's expense. Under no circumstances will original x-rays be released. X-rays, when taken, will be reviewed at the patient's Report of Findings appointment.

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Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements have been made before services are rendered. If your account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in the collection process, including a $35 administration fee.

I acknowledge that my information is private and confidential, however, I also acknowledge and approve any necessary correspondences with various third parties, including my GP, specialist and/or insurance company.

New Life Chiropractic Center provides an appointment reminder service by email, SMS, or phone call. We may also communicate with you by SMS and email from time to time, for the purposes of clinic announcements and patient education.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

New Life Chiropractic conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. By signing below, you acknowledge that you have been made aware of its availability.

Method of payment preferred for today's charges:

☐ Cash ☐ Check ☐ Visa/Master/Discover ☐ Care Credit

Name: _____ Signature: _____ Date: _____

Witness: _____ Signature: _____ Date: _____

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