Date: _____
HR#_____

New Practice Member Paperwork

Name: _____ Birthdate: _____-_____-_____ Age: _____ ◯Male ◯ Female

Height: _____ Weight: _____ **Females only:** Are you pregnant ◯Yes ◯No How many weeks? _____

Address: _____City: _____ State: _____ Zip:_____

Phone Cell: _____ Home: _____ Do you have insurance? ◯Yes ◯No

E-mail Address: _____ Marital Status: ◯Single ◯Married

Social Security #: _____ Employer / Occupation: _____

Spouse's Name _____ Number of children _____ Names, Ages & Gender_____

_____

Name & Number of Emergency Contact: _____ Relationship: _____

LIST THE HEALTH CONCERNS THAT BROUGHT YOU INTO THIS OFFICE

Please identify the condition(s) that brought you to this office:

	List Concerns According to Severity	Rate of Severity 0= No Pain 10= Unbearable	When did this problem start?	When is the problem at it's worst? (AM, PM, Mid-day)	How long does it last?	Are symptoms constant (C) or intermittent (I) ?
Primary						
Second						
Third						
Fourth						

List Restricted Activity **Current Activity Level** **Usual Activity Level**

_____ _____ _____

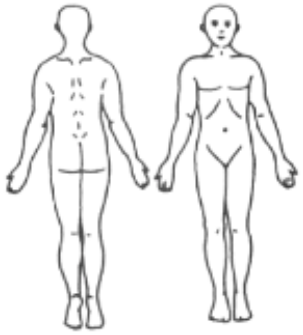
_____ _____ _____

_____ _____ _____

Is your problem the result of ANY type of accident? ◯ Yes ◯ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____



PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/Stabbing **T** = Tingling

What relieves your symptoms? _____

What makes your symptoms feel worse? _____

PAST HISTORY

How did the injury happen?_____

Have you suffered with any of this or a similar problem in the past? ◯ No ◯ Yes **If yes,** how many times? _____

When was the last episode? _____ Has this condition ever been treated by anyone in the past? ◯ No ◯Yes If yes, when?_____

by whom?_____ Other forms of treatment tried: ◯ No ◯ Yes **If yes,** please state what type of treatment: _____

,and who provided it? _____How long ago? _____ What were the results. ◯ Favorable ◯ Unfavorable

Please explain:_____

Name of previous chiropractor:_____ ◯N/A

Please identify any & all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

____ Broken Bone ____ Dislocations ____ Tumors ____ Rheumatoid Arthritis ____ Fracture ____ Disability ____ Cancer

____ Heart Attack ____ Osteo Arthritis ____ Diabetes ____ Cerebral Vascular ____ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ◯No ◯ Yes **If yes,** whom?

◯ grandmother ◯ grandfather ◯ mother ◯ father ◯ sister(s) ◯ brother(s) ◯ son(s) ◯ daughter(s)

Have they ever been treated for their condition? ◯ No ◯ Yes ◯ I don't know ◯ N/A

2. Any other hereditary conditions the doctor should be aware of? ◯ No ◯ Yes: _____

SOCIAL HISTORY

1. Smoking - how often? ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

2. Alcoholic Beverage - how often? ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

3. Recreational Drug - how often? ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

4. Exercise - how often? ◯ Daily ◯ Weekends ◯ Occasionally ◯ Never

Have you consumed any caffeine or products with caffeine in the past 48 hours? ◯ Yes ◯ No

PLEASE MARK "P" FOR IN THE PAST OR MARK "C" FOR CURRENTLY HAVE

___Headaches	___Loss of Energy	___Digestive Issues	___Sexual Dysfunction
___Migraines	___Nervousness	___Diarrhea	___Sleep Problems
___Jaw / TMJ Pain	___Double / Blurry Vision	___Constipation	___Tight / Sore Muscles
___Neck Pain	___Anxiety	___Bed Wetting	___Sports Injury
___Shoulder Pain	___ADD / ADHD	___Kidney Problems	___Sciatica
___Arm Pain	___Loss of Balance	___Bladder Problems	___Arthritis / Joint Pain
___Upper Back Pain	___Depression	___Menstrual Problems	___GERD/Gastric Reflux
___Mid Back Pain	___Allergies	___Prostate Problems	___Numb / Tingling in Arms/Hands
___Lower Back Pain	___Sinus Issues	___Infertility	
___Hip / Leg Pain	___Frequent Colds	___Fibromyalgia	___Numb / Tingling in Legs/Feet
___Knee Pain	___Thyroid Issues	___Epilepsy / Convulsions	___Stomach Problems
___Foot Pain	___Asthma	___Tremors	___High / Low Blood Pressure
___Ear Infections	___Chest Pain	___Disc Problems	___Difficulty Breathing
___Hearing Loss	___Heart Problems	___Scoliosis	
___Ringing in the Ears	___Nausea	___Poor Posture	
___Dizziness	___Ulcers	___Skin Problems	

___ Pregnant ___ Stroke ___ Cancer ___ Heart Attack ___ Spinal Surgery ___ Spinal Bone Fracture ___ Scoliosis

___ Diabetes ___ Arthritis ___ Seizures Other:_____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sit to Stand	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Climb Stairs	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Pet Care	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Extended Computer Use	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Lift Children/Groceries	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Read/Concentrate	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Getting Dressed	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Shaving	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sexual Activities	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sleep	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Static Sitting	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Static Standing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Yard work	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Walking	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Washing/Bathing	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Sweeping/Vacuuming	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Dishes	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Laundry	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Garbage	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Driving	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform
Other: _____	◯ No Effect	◯ Painful (can do)	◯ Painful (limits)	◯ Unable to Perform

List Prescription & Non-Prescription drugs you take:_____

_____

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question asked, 0=no pain and 10=unbearable. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

1. How would you rate your pain RIGHT NOW

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at BEST? (How close to 0 does your pain get at its best?)
   What percentage of your awake hours is your pain at its BEST? _____%

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)
   What percentage of your awake hours is your pain at its WORST? _____%

0 1 2 3 4 5 6 7 8 9 10

If This Health Profile is for a Minor / Child, Please Fill Out and Sign Below Written Consent for a Child

Name of Practice Member who is a minor / child: _____

I authorize Dr. Tadd Terry, D.C., and any and all Modern Chiropractic Company staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my minor / child. As of this date, I have the legal right to select and authorize health care services for my minor / child. If my authority to select and authorize care is revoked or altered, I will immediately notify Modern Chiropractic Company.

Guardian signature: _____ Date: _____

Relationship to minor / child: _____

Informed Consent for Chiropractic Care

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often minimal, complications such as sprain/strain injuries, irritation of a disc condition, dislocations of joints, and although very rare, fractures, and possible stroke (estimated to be related in one in one million to one in two million cervical adjustments), have been associated with chiropractic adjustments.

Prior to receiving chiropractic care in the chiropractic office, health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I authorize and request payment of insurance benefits directly to Dr. Tadd Terry, D.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print name: _____

Signature:_____ Date: _____

We love to have pictures in our office!

If you would allow us to have your picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Modern Chiropractic Company, or anyone authorized by Modern Chiropractic Company, of any and all photographs/videos which were taken of myself and/or my child, for the purposes of promotional TV, website, social media, and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute the property of Modern Chiropractic Company, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above-listed information for purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Modern Chiropractic Company to share this information via their website and their social media platforms including but not limited to Facebook and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: x-rays are not utilized in this office to help locate and analyze vertebral subluxations. The Doctor of Modern Chiropractic Company does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring them to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Print name:_____ Date of Birth: _____

Signature: _____ Date: _____

FEMALES ONLY: To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time the x-rays are taken at Modern Chiropractic Company.

The first day of my last menstrual cycle was on _____-_____-_____ (Date)

_____	_____	_____/_____ /_____
Patient or Parent / Authorized Person Name (print)	Patient or Parent / Authorized Person Signature	Date