FORSYTH CHIROPRACTIC
517 COY BLVD, FORSYTH, MO 65653

PHONE: 417-546-2411
FAX: 417-546-2730

New Patient Information

How were you referred to our office?_____

Name:_____ Age:_____ Sex:____ Today's Date:_____

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

Phone:_____ Work:_____ Cell:_____ Cell Provider:_____

Social Security #:_____ Birthdate:_____ E-mail address:_____

Race:_____ Ethnicity: Hispanic Non Hispanic Marital Status: Single Married Widowed Divorced

Occupation:_____ Employer:_____

Employer's Address:_____ Employer Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Parent's Name if Patient is Minor/Child:_____ Parent's Employer:_____

Emergency Contact Name:_____ Phone:_____ Relationship:_____

Name of Nearest Relative:_____ Address:_____Phone:_____

Family Medical Doctor:_____ Phone:_____

Please check any and all insurance coverage that may be applicable in this case**:**

☐ Major Medical ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Auto Accident
☐ Medical Savings Account ☐ Flex Plan ☐ Other _____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

CONTACT RELEASE INFORMATION: I agree to permit this chiropractic office and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Patient's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: □ Auto □ Work □ Other: _____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe:_____

_____

If Auto Accident: Date: _____ Time: _____ Location: _____

Were You: □ Driver □ Passenger □ Wearing Seatbelt

□ Unconscious □ Transported by Ambulance □ Treated in E.R.

Was there a Police Report, if yes, what Police Dept: _____

If Work Accident: Date: _____ Time: _____ Location: _____

Describe injury & how it happened: _____

Accident was reported to: _____ Days lost from work: ____ Date of last physical examination: _____

Describe your pain (check all that apply):

□ Aching □ Burning □ Cramping □ Deep □ Dull □ Non-radiating

□ Radiating to _____ □ Sharp □ Squeezing □ Stabbing □ Throbbing □ Tightness □ Vague

What, if anything, gives you RELIEF (check all that apply):

□ Activity □ Lying down □ Movement □ Pain relievers □ Rest □ Sitting

□ Standing □ Stretching □ Turning □ Twisting □ Walking □ Other: _____

What, if anything, makes it WORSE (check all that apply):

□ Activity □ Lying down □ Movement □ Pain relievers □ Rest □ Sitting

□ Standing □ Stretching □ Turning □ Twisting □ Walking □ Other: _____

Was onset of pain: □ sudden or □ gradual?

Rate your pain on a scale of 1 to 10: _____

When do you notice it: □ End of day □ Night □ Morning

How often do you feel it: □ Constant □ Frequent □ Occasional

Do you have a history of □ Stroke □ Hypertension?

Have you had any major illnesses, injuries, falls, auto accidents or surgeries (with dates)? Women, please include information about childbirth (with dates): _____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? □ Yes □ No If yes, describe: _____

Do you have any allergies of any kind? □ Yes □ No If yes, describe: _____

Do you have any Congenital Condition? □ Yes □ No If yes, describe: _____

Women: Are you pregnant? □ Yes □ No

PATIENT Signature _____ DATE _____

Doctor Signature _____DATE _____

Review of Systems

Have you had or do you now have any of the following symptoms/conditions?
Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now		P = Previously
Headaches	_____	Frequent Colds	_____
Lights Bother Eyes	_____	Sinus Problems	_____
Loss of Smell	_____	Fever	_____
Loss of Taste	_____	Coughing Blood	_____
Buzzing in Ears	_____	Diabetes	_____
Ears Ring	_____	Ulcers	_____
Dizziness	_____	Gall Bladder Problems	_____
Loss of Balance	_____	Unusual Bowel Patterns	_____
Fainting	_____	Indigestion Problems	_____
Neck Pain	_____	Menstrual Difficulties	_____
Stiff Neck	_____	Difficulty Urinating	_____
Shoulder Pain	_____	Chest Pains/Tightness	_____
Elbow Pain	_____	Breathing Problems	_____
Numbness in Fingers	_____	Pacemaker	_____
Hands Cold	_____	High Blood Pressure	_____
Rheumatoid Arthritis	_____	Low Blood Pressure	_____
Back Pain	_____	Circulating Problems	_____
Numbness in Toes	_____	Heart Disease	_____
Feet Cold	_____	Stroke	_____
Weakness in Extremities	_____	Ruptures	_____
Hip Pain	_____	Excessive Bleeding	_____
Knee Pain	_____	Depression	_____
Ankle Pain	_____	Alcoholism	_____
Muscle Spasms	_____	Eating Disorder	_____
Joint Pain/Swelling	_____	Drug Addiction	_____
Arthritis	_____	Loss of Memory	_____
Osteoarthritis	_____	Seizures/Epilepsy	_____
Fatigue	_____	Osteoporosis	_____
Sleeping Problems	_____	Broken Bones/Fractures	_____
Nervousness	_____	Weight Loss/Gain	_____
Irritability	_____	Cancer	_____
Tension	_____	HIV Positive	_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

O = OFTEN S = SOMETIMES N = NEVER

Caffeine _____
Drug Use _____
Alcohol Use _____

Vigorous Exercise _____
Moderate Exercise _____
High Stress Activity _____

Tobacco Use _____ Number of Years _____ Years Quit _____

PATIENT Signature _____ DATE _____
Doctor Signature _____ DATE _____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTER(S) Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

INFORMED CONSENT

PATIENT NAME _____

Clinic Name Forsyth Chiropractic

Doctor's Name Dr. Travis Sellers and/or Dr. Dakota Freiborg

Address 517 Coy Blvd, PO Box 99, Forsyth, MO 65653

Phone (417) 546-2411 Fax (417) 546-2730

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a ”Spinal Manipulation” or “Spinal Adjustment”. As the joints in your spine are moved, you may experience a “pop” as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner’s Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take you clinical history.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

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