Achieving Health Clinic
New Patient Information

Patient_____

Cell#_____Home#_____

Address_____

City_____ST____Zip_____

E-Mail (please print)_____

For massage appointment reminders do you prefer a: Text or Phone Call?

Date of Birth_____Age_____

Married_____ Single_____

How Did you hear about us?_____

Do you have a Health spending acct, Flex spending, or similar acct? Y or N

Do You Have Health Insurance? Y or N SS#_____

Employer_____

If yes, PLEASE give your Insurance Card and Driver's License to our Chiropractic Assistant

****Any Patient receiving Massage Therapy in the office is required to give a 24 hour cancellation notice, for any scheduled massage appointment. If a 24 hour notice is not given, we reserve the right to charge a $30 fee for the missed appointment, which will be due at your next appointment.**** **Please initial below that you have read**

Initials _____

X-RAYS

_____

_____

Office Use Only

Please be as accurate as possible.

Occupational / Lifestyle

On average how many total hours a night are you in bed (sleep, reading, watch tv) ?_____

What position do you typically sleep in; L Side R Side Back Stomach

How old is your mattress?_____

How would you describe your mattress? Firm Medium Soft Pillow Top Sleep number

How many pillows do you sleep with?_____

Current occupation?_____

How many hours a week do you work?_____

What type of activity/position does your work mainly consist of?_____

_____

_____

On average while at work how many hours a day are you doing this activity/position?_____

Additional non-work hours spent at a desk/laptop/computer during the week?_____

If you have any kids what are their ages?_____

How many hours a day are spent physically taking care of your kids?_____

Carry a large purse or bag? Yes or No, If yes which side the most?_____

Hobbies / Activity

Do you do stretches during the week? No 1-2 Days 3-4 Days Daily

Type of exercise and hours/week-

Cardio_____ Weight lifting_____ Aerobic_____ Yoga_____ Other_____ None

Hobbies or Activities 1 and frequency?_____

Hobbies or Activities 2 and frequency?_____

Hobbies or Activities 3 and frequency?_____

Are you wearing __ Heel Lift __ Arch Supports __ Orthotic Inserts

Do you regularly receive a massage for stress relief or rehabilitation? __Yes __No

Do you have a preference in therapist? _____Male _____Female _____ No preference

Chief Health Complaint_____

How long have you noticed this complaint_____

Is This Condition; Job Related __ Auto Accident __ Home Injury __ Fall __ Other__

List any Accidents or Falls Along With Dates in Past 5 Years_____
_____

Rate Your Pain Today (no pain) 1—2—3—4—5—6---7—8—9—10 (severe pain)

Have You Ever Experienced This Condition Before __No If yes, When _____

Have You Seen Anyone For This Condition Before __No If yes, Who_____

Diagnosis_____

Treatment_____

Have You Seen A Chiropractor Before? ____Yes _____ No If Yes last visit Date ?_____

Check all of the following daily activities this condition is interfering with?

_Bend to put on shoe
_Shower/Bath
_Driving Car
_Get in Car
_Get out of Car
_Carry object less than 10lbs
_Carry object 10lbs or greater
_Sitting
_Standing
_Getting up from lying
_Sleeping
_Reaching overhead
_Going up/down stairs
_Bend at the waist
_Squatting
_Working on the computer
_Walking
_Eating
_Cooking
_Housework
_Yard work
_Coughing / Sneezing
_None

Do you have any other health complaints?_____

For Women: Are You Pregnant __ Yes __ No

Are You Currently Nursing __ Yes __ No If so, How many Weeks _____

By my signature on this form, I do hereby state that, to the best of my knowledge, I am not PREGNANT, NEITHER suspected nor confirmed at this particular time.

Patient's signature:_____

Medical History

Please Check Any of the Following You Have Had or Currently Have

Musculo-Skeletal

_Neck Pain/Stiffness
_Mid-Back Pain/Stiffness
_Low Back Pain/Stiffness
_Jaw Pain or click (TMJ)
_Shoulder Pain
_Hip Pain L or R
_Knee Pain L or R
_Ankle Pain L or R
_Arthritis
_Osteoporosis
_Vertebral Disc Bulge/Herniation
Levels_____

Have you every broke/fracture/injured

_Clavicle
_Rib
_Spine
_Hip L or R
_Leg L or R
_Knee L or R
_Ankle L or R
_Foot L or R

Nervous System

_Numbing/Tingling in Butt, Legs, or Feet
_Radiating Pain in Butt, Legs, or Feet
_Numbing/Tingling into arm, hand, fingers
_ Radiating Pain into arm, hand, fingers
_Trouble Sleeping
_Headaches
_Migraines
_Seizures/Convulsions
_Dizziness
_Fainting

Genito-Urinary

_Blood in urine
_Frequent urination
_Loss of bladder control

Cardiovascular

_Stroke
_Low Blood Pressure
_High Blood Pressure
_Irregular Heartbeats
_Poor Circulation
_Arteriosclerosis
_Thrombosis/Phlebitis
_Varicose Veins

Others

_Autoimmune Disorder
_Cancer
_Diabetes
_Fibromyalgia
_Hernia and Type_____

Family History

Do any family members below have any of the conditions on this page?

_Mother
_Father
_Brother
_Sister
_Child
_Spouse

List any Surgeries you have had with dates;

_____ _____
_____ _____
_____ _____

Achieving Health Chiropractic

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient,
and “Chiropractor” refers to Achieving Health Clinic.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent by email or asking for one at the time of my next appointment.

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases the following may occur but not limited to fractures, disc injuries, strokes, dislocations and sprains. I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_____ _____

Signature of Patient or Personal Representative Printed Name of Patient

_____ _____

Date of Signing Description of Personal Representative’s Authority