ELITE CHIROPRACTIC
108 SILVER LADY LN, BRANSON WEST, MO 65737

PHONE: 417-272-9191
FAX: 417-272-9797

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**

Condition	N/P	Condition	N/P
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 ________ Vigorous Exercise ________
Drug Use ________ Moderate Exercise ________
Alcohol Use ________ 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 Elite Chiropractic

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

Address 108 Silver Lady Lane, Branson West, MO 65737

Phone (417) 272-9191 Fax (417) 272-9797

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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