New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____
This is primarily a referral based practice, please tell us which of our patients referred you to Maryland Spine Care:

_____

Family Doctor _____ Address _____ Phone_____

Mailing address

Address _____ City _____ State _____ Zip _____
Telephone (**Cell**) ( ) -- (**Home**) ( ) --
Age _____ Birth Date _____ Social Security # _____ - _____ - _____
Occupation _____ Employer_____
Marital Status _____ Spouse's name _____ Spouse's Occupation _____
Spouse's employer _____ Spouse's Date of Birth _____
Emergency contact _____ Phone _____

Current Complaints

Nature of injury: ❑ Automobile ❑ Work ❑ Other
Please describe _____
_____
Date of injury _____ Date symptoms appeared _____
Have you ever had same condition? ❑ No ❑ Yes If yes, when? _____
List other practioners seen for this injury/condition _____
Have you ever been under chiropractic care? ❑ No ❑ Yes
If yes, please describe _____

Insurance Information (Some services are not covered by insurance.)

Name of **Primary Person Insured** _____ Date of Birth ____ / ____ / _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and patient. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if any outstanding balances remain on my account longer than 90 days after the date of service, legal collection may ensue and I will be responsible for any reasonable attorney fees, court costs, or other collection costs that may arise during the collection process. If I have a credit card on file with your office you may charge any outstanding balances as they occur to that credit card.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____

***Please have front desk copy your driver's license.**

Medical History

Have you been treated for any conditions in the few years? ❑ No ❑ Yes

If yes, please describe _____
_____

Date of last physical exam _____. Is there a chance that you are pregnant? ❑ No ❑ Yes

Have you had X-rays/ MRI taken? ❑ No ❑ Yes If yes, where? _____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	❑	❑	_____
Been hospitalized?	❑	❑	_____
Been in an auto accident?	❑	❑	_____
Had Sprains/Strains?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had surgery?	❑	❑	_____
Stroke / TIA	❑	❑	

Family History	
Family Member	**Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)**

Consent to Treat Minor

I hereby give consent to treat my child or minor. I have read the informed consent.

Patient Name_____ Parent/Guardian Signature_____

HIPPA Notice

In accordance with the federal privacy rule, 45 CFR parts 160 and applicable state law, we are committed to maintaining the privacy of your protected health information. A notice of your rights regarding these privacy issues is available upon request and your signature below verifies that you understand that a copy is available upon request.

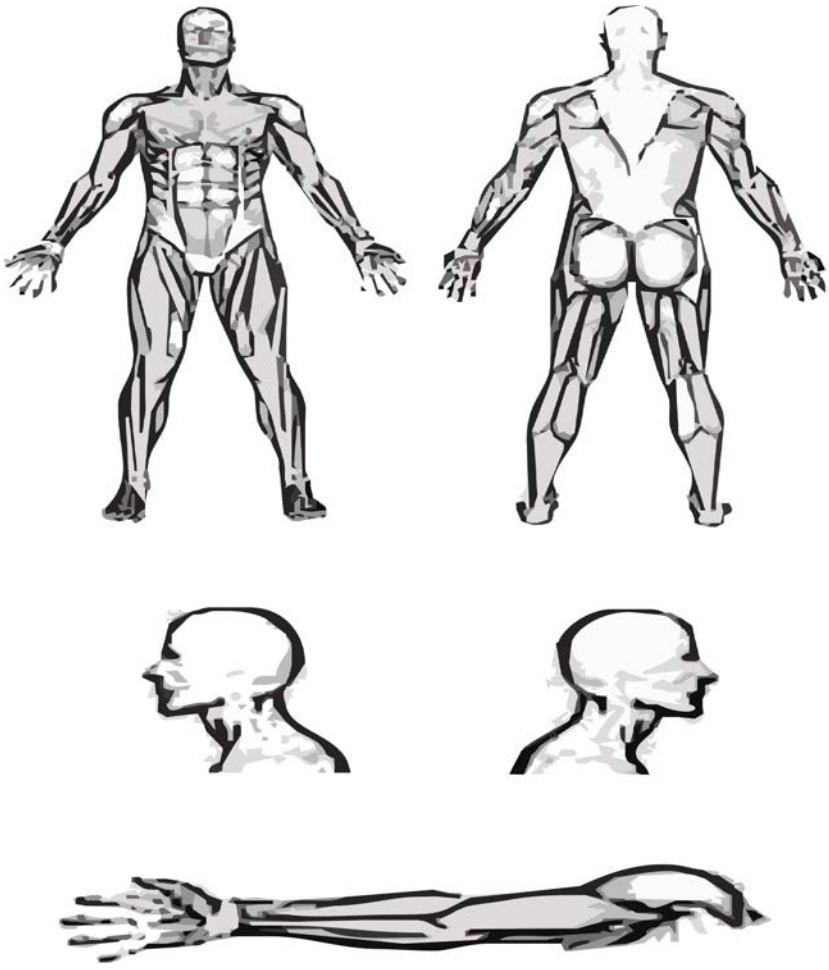
Patient Signature _____ **Date** _____

Have you ever suffered from or have:

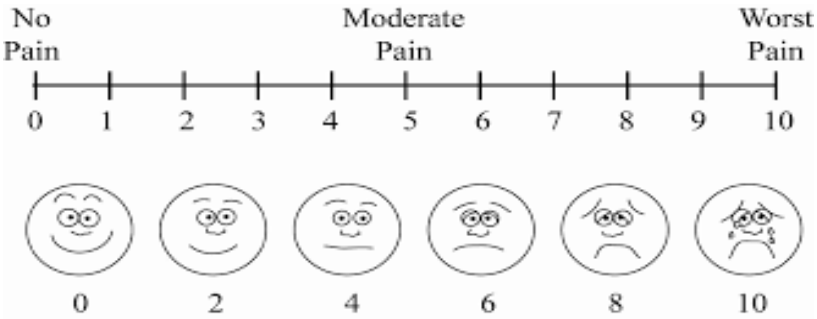
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chest Pain/Conditions
- ❑ Cold extremities
- ❑ Constipation
- ❑ Cramps
- ❑ Depression
- ❑ Diabetes
- ❑ Digestion Problems
- ❑ Dizziness
- ❑ Ears Ring
- ❑ Excessive Menstruation
- ❑ Eye Pain/Difficulties
- ❑ Fatigue
- ❑ Frequent Urination
- ❑ Headache
- ❑ Hemorrhoids
- ❑ High Blood Pressure
- ❑ Hot Flashes
- ❑ Irregular Heart Beat
- ❑ Irregular Cycle
- ❑ Kidney Infection
- ❑ Kidney Stones
- ❑ Loss of memory Loss of balance
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Neck Pain or Stiffness
- ❑ Nervousness
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Polio
- ❑ Poor Posture
- ❑ Prostate Trouble
- ❑ Sciatica
- ❑ Shortness of breath
- ❑ Sinus Infection
- ❑ Sleep problems/insomnia
- ❑ Spinal Curvatures
- ❑ Stroke
- ❑ Swelling of ankles
- ❑ Swollen Joints
- ❑ Thyroid Condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Venereal Disease

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing



Visual Pain Scale: Please circle a number.



INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, weight loss programs, detoxification programs, etc. on me by the doctor of chiropractic named above and/ or other Chiropractic Assistants and/ or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, though very rare, which may arise during chiropractic treatments. Those complications include but are not limited to: FRACTURES, DISC INJURIES, DISLOCATIONS, MUSCLE STRAIN, HORNER'S SYNDROMES, DIAPHRAGMATIC PARALYSIS, CERVICAL MYELOPATHY, COSTOVERTEBRAL STRAINS, SEPARATIONS, AND/ OR WORSENING OF MY CURRENT SYMPTOMS. Some types of manipulation of the neck, though very rare, have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, risks of chiropractic treatments, and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments and other procedures and/or programs. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that it is in my best interest to receive treatment at Maryland Spine Care. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

Name _____ Birth Date _____/_____/_____

Cell Phone: ( ) _____ - _____ Email : _____ @ _____

Smoking Status:

1) ____ Current Daily ____ Current Some Days ____ Former Smoker ____ Never Smoked

2) If smoked then start date: _____/_____/_____ 3) Number of Years smoked _____

4) Packs Per Day _____ 5) Number of Years since Quitting _____

6) Level of Interest in Quitting (Circle One)

0 1 2 3 4 5 6 7 8 9 10

No Interest → Most Interest

Medications:

Name	Reason Taking	Dosage	Start Date

List any known allergies to medication & reaction:

_____ _____

_____ _____

_____ _____

Have you been diagnosed with Hypertension? Yes No

If yes describe _____

Have you been diagnosed with Diabetes? Yes No

If yes was your blood lab-work test for hemoglobin A1c > 9.0%?

Yes No Not Sure

Supplements:

Name	Reason Taking	Dosage	Start Date

Height _____ inches Weight _____lbs. (Doctor Only) B.P. _____/_____ Pulse _____

Maryland Spine Care

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Authorization to Release/Receive Medical Records

Patient Name: _____

Date of Birth: _____/_____/_____

This authorization allows Maryland Spine Care to **release *all* records** you may have on file with us. This authorization will also allow us to **receive *all* records** from other parties.

Dates Requested:

From _____/_____/_____ thru _____/_____/_____

Patient Signature: _____

Date: _____/_____/_____