

NEW PATIENT INFORMATION

Name _____ Today's Date _____

Preferred Name _____

Address _____ City _____ State _____ Zip _____

Gender M _____ F _____ Other _____ DOB _____ Age _____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____

Email Address _____

Marital Status Single Married Divorced Partnered Widowed

Spouse/Partner Name _____

Spouse's Employer _____

Cell Phone (____) _____ Work Phone (____) _____

Is your spouse/partner a patient of the clinic? Yes _____ No _____

Emergency contact other than spouse/partner _____

Cell Phone (____) _____ Work Phone (____) _____

Do we have your permission to share your account or appointment information with a spouse or another person?

Yes _____ No _____ Who? _____

How did you hear about us? _____

Level of Education High School _____ Some College _____ College Grad _____ Post Grad _____

Occupation _____ Type of Work _____

Employer Name _____ Address _____

This work requires Sitting _____ Standing _____ Walking _____ Lifting _____

Typical Schedule Days _____ Evenings _____ Shift _____

Have you been seen by a Chiropractor prior to this visit? Yes _____ No _____

If so, where? _____ When? _____

Reason for visit? _____

Location of Primary Complaint _____

Complaint began when and how? _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint _____

Location of Secondary Complaint _____

Complaint began when and how? _____

Please circle the type of complaint/pain: dull aching sharp shooting burning throbbing deep nagging

Does this complaint/pain radiate or travel to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

Frequency of pain, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, imaging, lab tests or other care you've received for your complaint _____

Previous injury, concussion or trauma or broken bones? _____

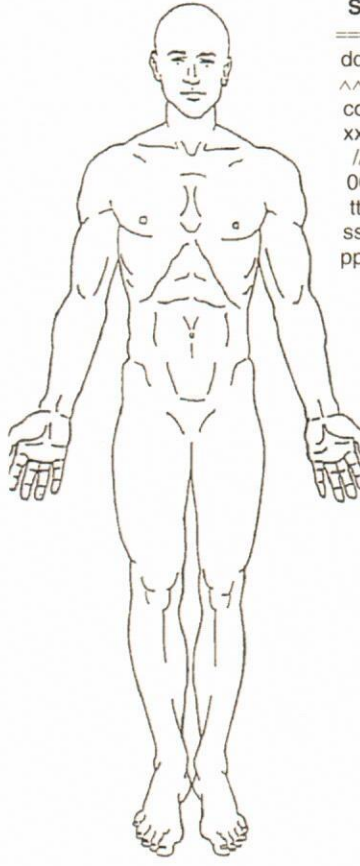
When? _____

Which bone(s)? _____

Print Patient Name _____ **Date** _____

PAIN DIAGRAM

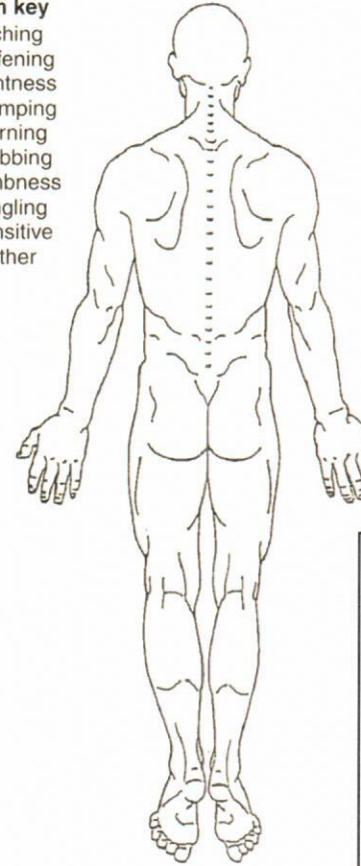
Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:



Right Left

Symptom key

- ===== Aching
- dddd Stiffening
- ^^^^ Tightness
- cccc Cramping
- xxxx Burning
- //// Stabbing
- 000 Numbness
- tttt Tingling
- ssss Sensitive
- pppp Other



Left Right

Height _____

Weight _____

Blood Pressure _____

Recreational Activities

- | | | | |
|-----------------------------------------|--------------------------------------|-------------------------------------|----------------------------------------|
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biking | <input type="checkbox"/> Pickleball | <input type="checkbox"/> Running |
| <input type="checkbox"/> Golfing | <input type="checkbox"/> Racquetball | <input type="checkbox"/> Tennis | <input type="checkbox"/> Rock Climbing |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Weight Lifting | <input type="checkbox"/> Football | <input type="checkbox"/> Basketball | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Cross Fit | <input type="checkbox"/> Dancing | <input type="checkbox"/> Yoga | <input type="checkbox"/> Other |

Print Patient Name _____ Date _____

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for awhile, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, Please circle all that apply, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Constitution (General Health) No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior or current diagnosis of cancer.

Other: _____

Ears, Nose, Mouth & Throat No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.

Other: _____

Heart & Blood Vessels No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Respiratory (Lungs & Breathing) No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.

Other: _____

GI (Stomach & Intestines) No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.

Other: _____

GU (Kidney & Bladder) No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Skin, Hair & Breast No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.

Other: _____

Psychiatric (Mood & Thinking) No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunological No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Print Patient Name _____ Date _____

Family and Personal Health History

__ Arthritis Parent / Sibling __ Thyroid Parent / Sibling __ HB Pressure Parent / Sibling
__ Cholesterol Parent/Sibling __ Cancer Parent / Sibling __ Stroke Parent / Sibling
__ Diabetes Parent / Sibling __ Psychiatric Parent / Sibling __ Other _____
__ Heart Problem Parent / Sibling

Immediate Family Deaths

Relation _____ Age at Death ____ Cause _____
Relation _____ Age at Death ____ Cause _____
Relation _____ Age at Death ____ Cause _____
Relation _____ Age at Death ____ Cause _____

Pregnancies/Children

Date _____ Outcome _____
Date _____ Outcome _____
Date _____ Outcome _____
Date _____ Outcome _____

Date of your last menstrual period? _____ Are you pregnant now? _____

Surgeries

__ Appendectomy __ Gall Bladder __ Rotator Cuff __ Other _____
__ ACL __ Lumbar Disc __ Prostatectomy __ Other _____
__ Cardiovascular __ Cervical Disc __ Prostate __ Other _____
__ Joint Replacement __ Mastectomy __ Hysterectomy __ Other _____
Specify _____ Partial ____ Full ____ Partial ____ Full ____

Prescription Medications and Over the Counter Supplements (Please List)

Please indicate if substance use is (M) Medicinal or (R) Recreational

__ Alcohol Past /Present __ Marijuana Past /Present __ Heroin Past /Present
__ Barbiturates Past/Present __ Amphetamine Past/Present __ Cocaine Past/Present
__ Crystal Meth Past/Present __ Tobacco Past/Present __ Other _____

Print Patient Name _____ Date _____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for Patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid at time of visit
- Cancellation/No Show policy: 24 hour notice is required for all appointment cancellations. A \$15.00 fee will be charged to the patient for all late cancellations and no shows.
- As a courtesy we send an appointment reminder, but you are responsible to keep track of your appointment day and time.

Self Pay Patients: When you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

Medical Insurance: As a courtesy to patients, we will bill your primary insurance carrier; however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. We are NOT contracted with any insurance companies; you will be balance billed if your company doesn't pay as quoted. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing payments be made directly to Tracy & Keim Chiropractic, LLC, medicare excluded. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan. PLEASE INITIAL THIS SPACE _____

Personal Injury/Auto Insurance: Regardless of who the responsible party is, a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. We require that you sign a lien form assigning payment to Tracy and Keim Chiropractic, LLC from an insurance company or from an attorney in cases where one has become necessary.

Worker's Compensation: You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

Patient Signature _____

Date _____

Print Patient Name _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND PATIENT INFORMED CONSENT FORM**

I, _____, (patient name) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Tracy & Keim Chiropractic, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

PATIENT INFORMED CONSENT FORM

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain informed consent before starting treatment.

I, _____, consent to examination and to the performance of conservative noninvasive treatments for my condition, by Dr. Sharell Tracy, Dr. Richard Keim, and/or Dr. Megan Wagner. I understand that the procedures may consist of manipulations involving movement of my joints and soft tissues, along with physical therapy modalities, rehabilitative exercises, x-rays, K-laser, electric therapies and nutraceuticals.

Although spinal and extremity manipulation is considered to be one of the safest and most effective forms of therapy for musculoskeletal problems, I am aware that, as with any form of therapy, there are possible risks and complications associated with these procedures, which are as follows:

- Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.
- Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
- Joint Injuries: I understand that in isolated cases, underlying physical defects, deformities of pathologies like weak bones from osteoporosis may render that patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be employed.
- Physical Therapy burns: Some of the therapies used in this office generate heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
- Strokes: Strokes from chiropractic manipulation are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur one in a million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests will be performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of all forms of medicine, including chiropractic, is not an exact science, and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

Patient Signature _____ Date _____

Doctor/Witness Signature _____ Date _____