



New Patient Information

Today's Date _____ Name (First, Middle Initial, Last) _____

Preferred Name if different from name listed above _____

Home Phone _____ Work Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Email Address _____ May we send you our email newsletter? Yes No

Best Way to remind you of next appt: Text message Email Home phone Work phone

Birth Date _____ Age _____ Social Security # _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Occupation _____ Employer _____

Employer Address and Phone _____

In case of emergency, contact: _____ Phone _____

Who may we thank for referring you to River Shores Chiropractic? _____

Insurance Information: *(If providing a copy of your insurance card, please fill out bold headings only)*

Insured's Name: _____ **Relationship** _____

Name of Insurance Company _____ ID # _____

Group # _____ Insurance Co. Address _____

Insured's Date of Birth _____ **Insured's Employer** _____

Do you have any secondary insurance? Yes No If so, please list secondary insurance info below:

Insured's Name: _____ **Relationship** _____

Name of Insurance Company _____ ID # _____

Group # _____ Insurance Co. Address _____

Insured's Date of Birth _____ **Insured's Employer** _____

Patient Condition Information

Reason for this visit _____

Is your complaint related to an accident or injury? Yes No

If yes, what type of accident or injury? Auto Sports Related Work Related Slip/Fall

I hereby authorize my insurance company benefits to be paid directly to Dr. Krysti Wick/ River Shores Chiropractic. I realize I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent information to the insurance company.

Patient or Legal Representative Signature _____ Date _____

River Shores CHIROPRACTIC

PATIENT HEALTH COMPLAINT FORM

Today's Date _____ Name _____

1. What is your chief complaint? _____

2. When did this complaint begin (date)? _____

3. What caused this problem? _____

4. Complaints/Disturbances: Come and Go Came on Gradually Came on Suddenly

5. Symptoms are better in: AM PM

6. Symptoms are worse in: AM PM

7. Symptoms have persisted for: Hours 1 day Days Weeks Months Years

8. Have you seen any other doctors for this condition? Yes No

If yes, please list name and address of doctor: _____

9. Have you ever had this condition/problem before? Yes No If yes, when? _____

10. When did you last have x-rays taken? _____

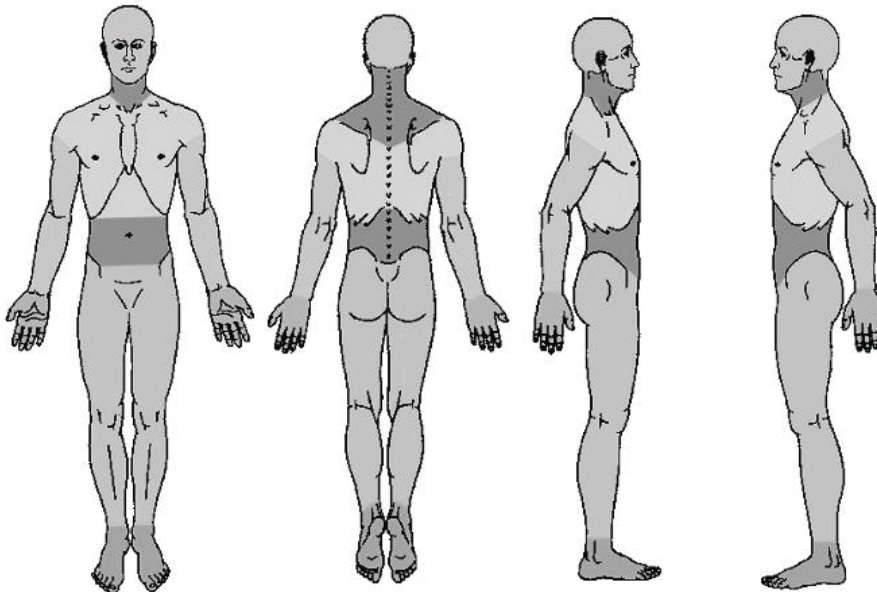
11. Indicate ability to perform the following activities:

(U= Unable, P= Painful, D= Difficult, L=Limited, N= Normal)

___ Coughing	___ Lying on Back	___ Sleeping	___ Turning over in bed
___ Sneezing	___ Lying Flat on Stomach	___ Stooping	___ Walking short distances
___ Laughing	___ Lying on side	___ Gripping	___ Standing More than 1 Hour
___ Bending Fwd.	___ Dressing Self	___ Pushing	___ Sitting at a Table
___ Climbing	___ Balancing	___ Pulling	___ Reaching

DISCOMFORT AREAS: Code areas to indicate location of pain or discomfort.

P= Pain, S= Spasm, N= Numbness, T= tingling, W= Weakness



Patient Signature _____ Date _____

Name: _____

Date: _____

Do you have any allergies? Yes No

Seasonal _____

Allergic Reactions to: _____

Habits:

Smoking ___Packs/Day

Alcohol ___Drinks/ Day or Week (circle one)

Coffee ___Cups/Day

Soda ___Cans/Day

Recreational Drug Use

Work Activity:

Sitting

Standing

Light Labor

Heavy Labor

Exercise:

None

1-2 times per week Type: _____

3-5 times per week Type: _____

6-7 times per week Type: _____

Injuries/Surgeries:

Description

Date

Auto Accident _____

Falls/ Major Injuries _____

Broken Bones/Dislocations _____

Surgeries _____

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

- | | | | | | |
|-------------------------------------|---|--------------------------------------|-------------------------------------|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Measles | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Polio | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Multiple Sclerosis |

Please list any medications you are presently taking. Include prescriptions, over the counter, oral contraceptives, vitamins & supplements, and the amount of each: _____

FAMILY HISTORY

(Include information about parents, grandparents, and siblings- do not include yourself)

- | | | | |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle/Bone/Nerve Disease | <input type="checkbox"/> Other _____ | |

Patient Signature _____

Date _____

Name: _____

Date: _____

River Shores Chiropractic Consent to Chiropractic Services

Payment and Insurance

Patient Initials _____

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent to Treatment of a Minor Child

I authorize Dr. Krysti Wick and whoever she may designate as a substitute to administer chiropractic care as deemed necessary to my:

(Relationship) _____ (Name) _____

Female Patients

Patient Initials _____

This is to certify that to the best of my knowledge I am NOT pregnant and that River Shores Chiropractic has my permission to take x-rays.

Beginning date of your last menstrual period _____

Consent to Chiropractic Services

Patient Initials _____

I hereby request and consent to chiropractic adjustments and other procedures including various modes of physical therapy, diagnostic x-rays, and/or tests performed by Dr. Krysti Wick and her staff who now or in the future treat me while employed by this office. I will have an opportunity to discuss with Dr. Krysti Wick and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and complications, and wish to rely on the Doctor to exercise judgment during the course of any procedure which the Doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signed: _____ Date: _____

Witness: _____ Date: _____