The Ranch Chiropractic Wellness Center **New Patient Registration and History**

Date: _____ Patient Date of Birth: _____ ○ Male ○ Female

Patient Name: _____ SS# ____-____-_____
First Name Middle Initial Last Name

Mailing Address: _____

City _____ State _____ Zip Code _____

Preferred Method of Contact: ○ Phone Call ○ Email

Best Phone Number to reach you: _____ ○ Home ○ Work ○ Cell

Employer: _____ Occupation:_____ Wk Phone:_____

E-Mail: _____
Our office may email you appointment reminders

Who can we thank for referring you? _____

○ Single ○ Married Spouse Name: _____ Spouse Phone # _____

Emergency Contact: Name: _____Relationship: _____ Phone: _____

Is the current condition we are treating related to the following:

Employment? ○ YES ○ NO Auto Accident? ○ YES ○ NO State: _____ Accident? ○ YES ○ NO

Insurance Co. _____ Policy Holder: _____ Relationship: _____

Policy ID # _____ Group # _____

Policy Holder Date of Birth: _____ Policy Holder Phone #: _____

Race & Ethnicity: □ White □ American Indian/ Alaskan Native □ Black/African-American
□ Latino/ Hispanic □ Native Hawaiian/ Pacific Islander

Preferred Language: □ English □ Spanish □ French □ German □ Japanese

Smoking Status: □ Current Smoker (Daily) □ Current Smoker (At Times) □ Former Smoker □ Never

Current Influenza Vaccination: ☐ No ☐ Yes, Date (Mo/Yr):_____

Prescribed Medication ○ Check if you are not taking any medications

Medication *Example: Lipitor*	**Dosage & Form** *2 x 300 mg tablets*	**Frequency** *3 x day*	**# of Refills Issued:**

Are you allergic to anything? ○ Yes: Food or Drug ○ No medical allergies

Allergy to What: _____ How it affects you: _____

Have you been diagnosed with Asthma? ○ YES ○ NO Diabetes? ○ YES ○ NO

INFORMED CONSENT FOR TREATMENTS and PRIVACY POLICY

- **The nature of Chiropractic Treatment:** The doctor will use his hands or a mechanical device in order to move joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation and therapeutic ultrasound may also be used.
- **Possible Risks:** Complications are possible following a chiropractic manipulation and could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.
- **Injectable Nutrients** are administered at this office. If this therapy applies to your care – all benefits, risks and alternatives will be explained by your doctor before you elect to receive this service. If you would like a copy of these benefits, risks and alternatives please ask the front desk.
- **Acupuncture** is a safe method of treatment, but it may have side effects, including bruising, tingling, numbness or mild pain near the needling sites that may last a few days and dizziness or fainting. Infection is another possible risk, although this office uses only sterile, disposable needles while maintaining a clean and safe environment. Although some insurance plans may cover acupuncture benefits our office does not bill for acupuncture. You are welcome to ask for an itemized bill of service to bill the services to your insurance company.
- **Graston Technique®** is an instrument assisted variation of cross fiber or transverse friction massage. GT is a form of treatment used to "break up" or soften scar tissue, thus allowing for the return of normal function in the area being treated. Graston Technique® may produce the following: 1. Local discomfort during the treatment. 2. Reddening of the skin. 3. Superficial tissue bruising.4. Post treatment soreness.
- I authorize staff of The Ranch Wellness Center to perform any necessary services needed during diagnosis or treatment. I authorize the provider to release any information required to process insurance claims.
- **All HIPPA guidelines and requirements are followed in this office If you would like a copy of the HIPPA requirements please ask for them at the front desk.**
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information I have provided. This includes all personal & insurance information.

DATE _____ SIGNATURE_____

FINANCIAL ARRANGMENTS

The filing of insurance is a courtesy that we extend to all patients; however, all charges are your responsibility and payment is due at the time services are rendered.

- There is a $25.00 service fee on all returned checks. ** **If your account reaches $250.00 you will be required to pay at least half that amount before receiving further treatment at this office. ****

DATE_____ SIGNATURE _____

CONSENT FOR X-RAY

I give my permission to The Ranch Wellness Center and its staff to take X-RAYS as deemed appropriate by the doctor. **I also hereby declare that to my knowledge, I am not pregnant.**

DATE _____ SIGNATURE_____

CONSENT TO TREAT A MINOR

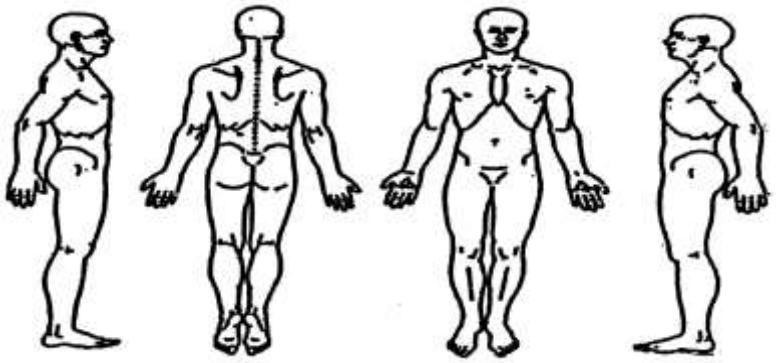
I hereby authorize Drs. Jerimy & Amy Cox and whomever they may designate as assistants to administer Chiropractic care as deemed necessary to my _____(indicate relationship to child), _____(child's name). DATE _____ SIGNATURE _____
(Parent or Guardian)

I would like to electronically have access to my health information: ○ YES ○ NO PLEASE INITIAL BOX

Reasons for Visit (list all)_____

_____

Indicate on the drawings where you have symptoms and/or pain.



Check All That Apply:

□ Pain □ Sickness □ Soreness □ Discomfort □ Muscle Spasm □ Function Loss □ Numbness

How did it begin?

_____

When did it begin? _____ **Did it begin** □ Gradually or □ Suddenly?

Is it the result of injury, trauma or activity? If yes explain: _____

The ailment/condition has been getting: □ Better □ Worse □ Same

What makes condition better: _____

What makes condition worse: _____

Is the pain Deep or Superficial? _____ **Sharp or Dull?** _____

Condition is: □ Constant □ Occasional □ Frequent □ Intermittent

Describe the feeling: □ Burning □ Tingling □ Aching □ Throbbing □ Gnawing □ Stiffness □ Tired □ Numbness □ Stabbing □ Shooting □ Radiating □ Constant Dull Ache, sharp with certain movements or activities □ Other:

_____

If condition radiates, list where it travels from and to: _____

Using a scale from 0-10 (10 being worst), rate feeling now: 0 1 2 3 4 5 6 7 8 9 10

Using a scale from 0-10 (10 being worst), rate the range: 0 1 2 3 4 5 6 7 8 9 10

Is condition worse at any time of day or time of month: _____

Have you had anything like this before: _____

Any change to your bodily functions (bowel or bladder changes)? _____

Any professional treatments or home remedies helped? _____

How have conditions affected your daily activities? _____

If employed how have conditions affected your work load? _____

Is your sleep disturbed by these conditions? _____

Do you sleep on your back, side or multiple positions? _____

Do you get Headaches or Migraines? _____**How often?** _____

Alcohol Use: □ None □ Occasional □ Frequent □ Daily □ Socially □ Infrequent □ Weekends

MEDICAL HISTORY

How is your general health? □ Excellent □ Good □ Fair □ Poor □ Undetermined

List past significant accidents or injuries: _____

List all surgeries/hospitalizations, and details: _____

Have you had any unusual diseases? _____

Have you been treated by a physician in the last year? Explain: _____

Have you received Chiropractic treatment previously? If so, please explain and if that helped your condition(s):

_____

Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Heart Problems □ Cancer □ ALS

For each condition listed, check the "past" column if you have had the condition in the past. If you presently have a condition listed below check the "present" column.

Now	Past		Now	Past		Now	Past	
□	□	Abdominal Pain	□	□	Irregular Menstrual Flow	□	□	Breast Lumps
□	□	Angina	□	□	Jaw Pain	□	□	Chest Pains
□	□	Aortic Aneurysm	□	□	Kidney Stones	□	□	Chronic Sinus Problems
□	□	Asthma	□	□	Loss of Appetite	□	□	IBS/Constipation
□	□	Bladder Infections	□	□	Low Back Pain	□	□	Diabetes
□	□	Breast Soreness	□	□	Muscular Incoordination	□	□	Dizziness/Fainting
□	□	Cancer	□	□	Pain in Upper Arm/Elbow	□	□	Lung Issues/Emphysema
□	□	Chronic Cough	□	□	Pain in Lower Leg/Knee	□	□	Epilepsy
□	□	Colitis	□	□	Painful Urination	□	□	Fatigue
□	□	Convulsions	□	□	Pregnancy	□	□	Heart Attack
□	□	Depression	□	□	Prostate Problems	□	□	High Blood Pressure
□	□	Drug Dependence	□	□	Rheumatoid Arthritis	□	□	Liver/Gallbladder Issues
□	□	Endometriosis	□	□	Shoulder Pain	□	□	Kidney Disorders
□	□	Excess Thirst	□	□	Swelling/Stiffness of Joints	□	□	Loss of Bladder Control
□	□	Frequent Urination	□	□	Tumor	□	□	Upper or Mid Back Pain
□	□	Hand Pain	□	□	Visual Disturbances	□	□	Neck Pain
□	□	Headache	□	□	Weight Change ABNORMAL	□	□	Pain Upper Leg or Hip
□	□	Heartburn/IBS	□	□	Arthritis	□	□	Pain Ankle or Foot
□	□	Hepatitis	□	□	Birth Control	□	□	Increased Heart Beat
□	□	Thyroid Disorder	□	□	Blood Disorder	□	□	Scoliosis
□	□	Tinnitus	□	□	Stroke	□	□	Other _____

Do you have a pacemaker: □ Yes □ No

Anything else pertinent to your visit today?

_____

_____

_____