Arsenault Chiropractic Center

Robert Arsenault, DC David Arsenault, DC Melissa Marr, DC

Welcome

Today's Date ____/____/____

Patient Name ____

FIRST MIDDLE INITIAL LAST

What you prefer to be called ______________ Male ____ Female ____

Birthdate ____/____/____ Age ____

Mailing Address ____

City ______________ State ______ Zip ______________

Home Phone # ______________ Cell Phone # ______________

Work Phone # ______________ Ext ______

Email Address ______________________

Referred By ______________________

Occupation ______________ How Long? ______________

Insurance Information

Insurance Company ________________________________

Insured's Name______________ Insured's Birthdate __________

Reason for visit

The reason for this visit is a result of (please circle) work, sports, auto, trauma or chronic.

Explain what happened ________________________________

Please describe the reason for this visit________________________________

When did condition begin? ____/____/____

Is this condition getting worse? ____ yes ____no ____constant ____comes and goes

Is this condition interfering with your (please circle) work, sleep or daily routine?

If so, please explain ________________________________

Have you been treated by a medical physician for this condition? ____ yes ____ no

If so, where? ________________________________

Have you ever been treated by a chiropractor before? ____ yes ____ no

If so, where/when? ________________________________

Health History

Are you taking any medications? If yes, please list

____

____

Please list anything you may be allergic to

____

____

Do you have or ever had any of the following?

Y	N	Heart attack/Stroke	Y	N	Heart surgery/Pacemaker	Y	N	Heart murmur
Y	N	Congenital heart defect	Y	N	Mitral valve prolapse	Y	N	Artificial valves
Y	N	Alcohol/Drug abuse	Y	N	Hepatitis	Y	N	Headaches
Y	N	Fibromyalgia	Y	N	Chemotherapy	Y	N	Cancer
Y	N	Asthma/Emphysema	Y	N	Diabetes/Neuropathy	Y	N	Anemia
Y	N	High/Low blood pressure	Y	N	Depression/Anxiety	Y	N	Lupus
Y	N	Fainting/Seizures/Epilepsy	Y	N	Sinus problems	Y	N	Ulcers
Y	N	Lower back problems	Y	N	Frequent neck pain	Y	N	Colitis
Y	N	Kidney problems	Y	N	Difficulty breathing	Y	N	Arthritis
Y	N	Artificial bones/joints	Other ______________________________					

Please list accidents or injuries you have had

____

____

List previous surgeries/treatments with dates

____

____

Please list any pertinent family health history

____

____

Do you take supplements or vitamins? ______yes ______no

Are you on a special diet? ______yes ______no Exercise? ______yes ______no

Do you smoke? ______yes ______no

Are you pregnant? ______yes ______no How long? ______ Nursing? ______yes ______no

What is your current weight __________ lbs Height ______ ft ______ in

Please describe your symptoms and list any additional information the doctor should be aware of

____

____

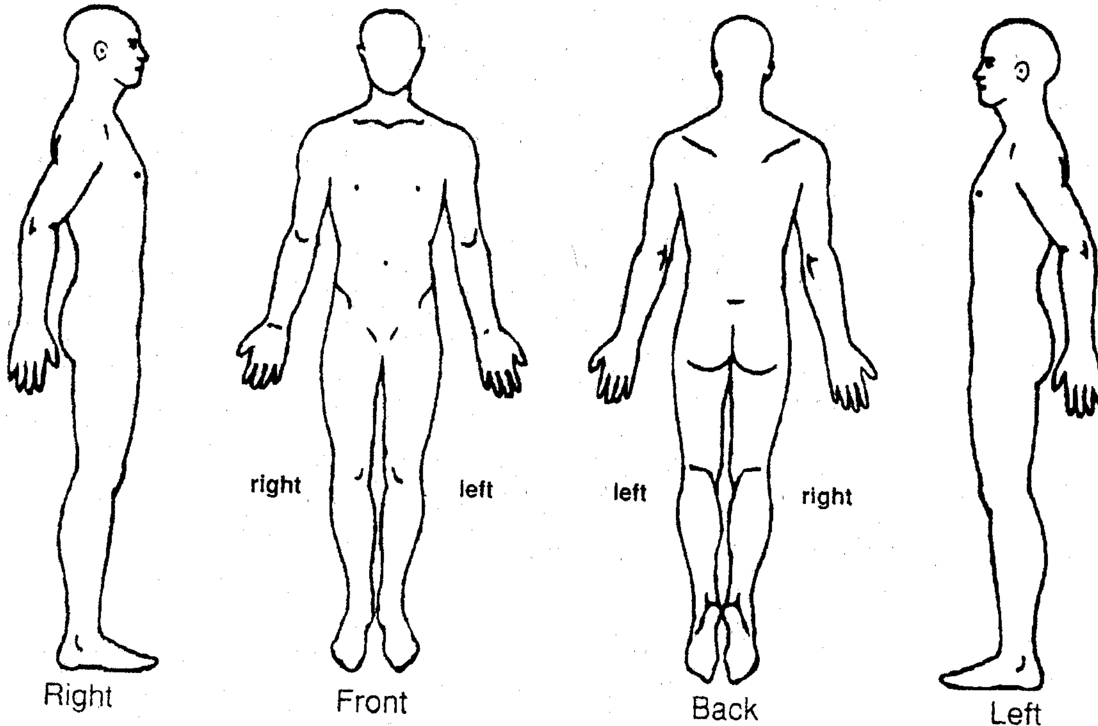
____

____

____

SHOW US WHERE IT HURTS

Please mark the area(s) where you are having pain and note if your pain travels anywhere.



I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand I may revoke this consent in writing at any time.

- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered and authorize the provider to release any information required to process insurance claims.
- I fully understand I am solely responsible for any balances not paid by my insurance company.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, and any other expenses incurred in collecting your account.
- 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 changes.

Signature X________________________________ **Date** ____________________

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New Patient Intake Form

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, by the chiropractor and/or anyone working in this office authorized by the chiropractor.

I further understand that such chiropractic services may be performed by a licensed chiropractor at Arsenault Chiropractic Center (who may treat me now or in the future at this office.) I have had an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications. Further, I wish to rely on the chiropractor to exercise judgment during the course of the procedure which the chiropractor feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

Print patient name ______________________________

Patient and/or guardian signature ____________________ **Date** __________

Chiropractor's signature ________________________ Date ______________