New Patient Application

Please print using black or blue ink only. If a section or question does not apply, mark N/A.

Appointment Date:

PATIENT INFORMATION

Last Name	First	MI	Age	☐ Male ☐ Female	Marital Status
Preferred Name/Nickname			Date of Birth		SSN#
Address	City		State		Zip
Cell Phone			Home Phone		
Email	Occupation		Employer		Job Description
Name of spouse & their employer			Name & Ages of children		
Who may we thank for referring you?			How did you hear about our office? ☐ Facebook ☐ Our website ☐ Yelp ☐ Instagram ☐ Google/Reviews ☐ Other:		

HISTORY OF COMPLAINT(S)

Health Concerns	Severity *(1=mild, 10=unbearable)*	When did it begin?	Have you had it before, if so, when?	Is the problem from an accident or injury?	Is it consistent pain or intermittent pain?	Has your symptom...
Example: Headaches	*6*	*1/10/15*	*1/15/13*	*Shoveling snow*	*Intermittent*	
1.						☐ Improved ☐ Worsened ☐ Stayed the same
2.						☐ Improved ☐ Worsened ☐ Stayed the same
3.						☐ Improved ☐ Worsened ☐ Stayed the same

AURORA CHIROPRACTIC

Please mark the areas on the diagram to the right with the following letters to describe your symptoms.

What relieves your symptoms?

What makes your symptoms feel worse?

Is your balance/walking ability affected? If yes, explain:

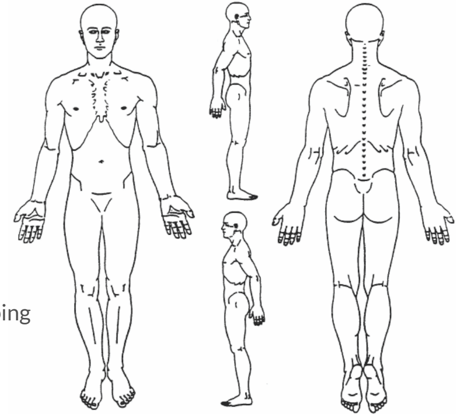
Name all doctors/therapists you have seen for these conditions and treatment you received:

What do you think is causing your condition(s)?

When is it at its worst?

- [ ] Morning
- [ ] Afternoon
- [ ] Evening

A Aching
B Burning
D Dull
N Numbness
R Radiating
S Sharp/Stabbing
T Tingling



QUADRUPLE VISUAL ANALOG SCALE (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

Example: *Headache* (2) *Neck* (5) *Low Back* (8)

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain RIGHT NOW?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain on AVERAGE?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain AT ITS BEST?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

How would you rate your pain AT ITS WORST?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

If you had to accept some level of pain after completion of treatment, what would be AN ACCEPTABLE LEVEL?

no pain 1 2 3 4 5 6 7 8 9 10 worst possible pain

ACTIVITIES OF DAILY LIVING

ACTIVITIES	EFFECT			
Carry/Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Use the Computer	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Get Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stand Statically	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
House/Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walk	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Wash/Bath/Shave	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes/Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Drive	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

CURRENT HEALTH PROBLEMS

Mark all that apply. This allows the doctor to have an overall view of your health status.

☐ Dizziness	☐ Asthma	☐ Menstrual Disorder	☐ Chronic Fatigue
☐ Headaches/Migraines	☐ Chest Pain	☐ Irritable Bowel	☐ Lupus
☐ Vertigo	☐ Heart Disease	☐ Sciatica	☐ Fibromyalgia
☐ Ear Infections	☐ High Blood Pressure	☐ Numbness in Legs	☐ Disc Problems
☐ Nausea	☐ Low Blood Pressure	☐ Numbness in Feet	☐ Arthritis
☐ TMJ	☐ Breathing Difficulty	☐ Low Back Pain	☐ Frequent Colds
☐ Anxiety	☐ Ulcers	☐ Bladder Problems	☐ Frequent Flu
☐ Chronic Sinusitis	☐ Stomach Disorders	☐ Hip Pain	☐ Emotional Disorder
☐ Throat Issues	☐ Kidney Problems	☐ Leg Pain	☐ Mental Disorder
☐ Thyroid Problems	☐ Mid-back Pain	☐ Knee Pain	☐ Epilepsy
☐ Numbness in Arms	☐ Gastric Reflux	☐ Infertility	☐ Nervousness
☐ Numbness in Hands	☐ Arm/Hand Pain	☐ Bedwetting	☐ Diabetes
☐ Shoulder Pain	☐ Neck Pain	☐ High Cholesterol	☐ Leg/Foot Pain
☐ Arm Pain	☐ Frequent Colds/Flu	☐ Menopausal Problem	☐ Other:

PAST HEALTH HISTORY

Mark any condition you have now or have had:

☐ Stroke	☐ Seizures	☐ Cerebral vascular disease	☐ Tumors
☐ Cancer	☐ Spinal bone fracture	☐ Scoliosis	☐ Rheumatoid arthritis
☐ Heart disease	☐ Broken bone	☐ Diabetes	☐ Osteoarthritis
☐ Spinal surgery	☐ Dislocation	☐ Knocked unconscious	☐ Other:

Explain:	
List all surgical operations and years:	
When was your last auto accident?	
Have you ever had previous chiropractic care, if so when and by whom?	
Other trauma(s):	
Any implant(s):	
List all medication and supplements:	
List all allergies/sensitivities to medication, food, and other items and their reactions:	

SOCIAL HEALTH HISTORY

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never
Alcohol consumption:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never
Recreational drug usage:	☐ Daily	☐ Weekends	☐ Occasionally	☐ Never

Hobbies, Recreational Activities, Exercise Regimen:

FAMILY HEALTH HISTORY

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Children

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Any other hereditary conditions the doctor should be aware of? ☐ Yes ☐ No

PATIENT QUALITY OF LIFE SURVEY

Please take several minutes to answer these questions so we can help you get better.
(Please mark all that apply)

Question			
How have you taken care of your health in the past?	☐ Medications ☐ Emergency Room ☐ Routine Medical	☐ Exercise ☐ Nutrition/Diet ☐ Holistic Care	☐ Vitamins ☐ Chiropractic ☐ Other
How did the previous method(s) work out for you?	☐ Bad results ☐ Some results ☐ Great results	☐ Nothing changed ☐ Did not get worse ☐ Did not work very long	☐ Still trying ☐ Confused
How have others been affected by your health condition(s)?	☐ No one is affected ☐ Haven't noticed any problem ☐ They tell me to do something	☐ People avoid me	
What are you afraid this might be (or beginning) to affect (or will affect)?	☐ Job ☐ Kids ☐ Future ability	☐ Marriage ☐ Self-esteem ☐ Sleep	☐ Time ☐ Finances ☐ Freedom
Are there health condition(s) you are afraid this might turn into?	☐ Family health problems ☐ Heart disease ☐ Cancer	☐ Diabetes ☐ Arthritis ☐ Fibromyalgia	☐ Depression ☐ Chronic Fatigue ☐ Need surgery

How has your health condition(s) affected your job, relationship, finances, family, or other activities? Please give examples	
What has that cost you (time, money, happiness, freedom, sleep, promotion, etc)? Please give examples	
What are you most concerned with regarding your condition(s)?	
Where do you picture yourself being in the next 1-3 years if this condition(s) is not taken care of? Please be specific	
What would be different/ better without this condition(s)? Please be specific	
What do you desire most from working with us?	
What would that mean to you?	

INFORMED CONSENT

Regarding Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Aurora Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or Authorized Person's Signature	*Date*	*Witness Initials*

Regarding X-Rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature	*Date*	*Witness Initials*

FEMALES ONLY

please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ________ *Date*

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

INSURANCE AUTHORIZATION

I hereby authorize payment to be made directly to Aurora Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Aurora Chiropractic for any and all service I receive at this office.

Patient or Authorized Person's Signature	*Date Completed*

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). . In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. I understand that this information can and will be used to:

1. Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.
4. Emergency - in the event of a medical emergency we may notify a family member
5. Telephone calls or emails and appointment reminders - we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICE containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Patient or Authorized Person's Signature	*Date Completed*	*Doctor's Signature*	*Date Form Reviewed*