NEW PATIENT APPLICATION & HISTORY

1 PATIENT INFORMATION

Date _____

Patient SSN _____

Patient Name _____
First Name Middle Initial Last Name

Address _____

City _____ State _____ Zip _____

Email _____ We will never share your e-mail with any third parties.

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Number of Children _____

Employer/School _____

Employer/School Phone (_____)_____

Occupation _____

Spouse's Name _____

Who may we thank for referring you? _____

Have you ever received chiropractic care before? ☐ Yes ☐ No

If yes, who was your chiropractor? _____

What kind of results did you have? _____

_____

Do you have a primary provider (MD)? ☐ Yes ☐ No

If yes, who is your doctor? _____

Where is he/she located? _____

2 INSURANCE INFORMATION

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Matthew J. Dunn all insurance benefits, if any, otherwise payable to me for services rendereed. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissons.

The above-named doctor may use my health care informatin and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Represenative

_____
Print name of Patient, Parent, Guardian or Personal Represenative

_____ _____
Date **Relationship to Patient**

3 PHONE NUMBERS

Home (_____)_____ Cell (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (_____)_____ Work (_____)_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

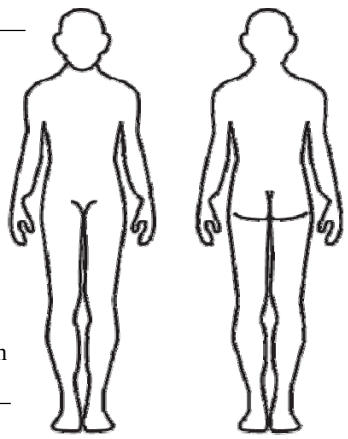
Attorney Name (if applicable) _____

5 CURRENT COMPLAINTS

Reason for Visit _____

When did your symptoms appear? _____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continute to have pain, numbness or tingling ——————>



Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Is there anything you do that makes it feel better? _____ Worse? _____

Does the pain shoot or radiate anywhere? _____

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	STD	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dep.	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	_____	

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week_____
- ☐ Coffee/Caffeine Drinks — Cups/Day_____
- ☐ High Stress Level — Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

7 MEDICATIONS

_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____

SUPPLEMENTS

_____
_____
_____
_____
_____

Please take several minutes to answer these questions so that Dr. Dunn can better understand your condition.
(**Please circle as many that apply**)

1. How have you taken care of your health in the past?
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. How have others been affected by your health condition?
   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. Are there any health conditions you are afraid this might turn into?
   a. Heart disease
   b. Cancer
   c. Diabetes
   d. Arthritis
   e. Fibromyalgia
   f. Depression
   g. Chronic Fatigue
   h. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples: _____
_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:
_____
_____

What are you most concerned with regarding this problem? _____
_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific:
_____
_____

What would be different/better without this problem? Please be specific:
_____
_____

What do you desire most to get from working with us?
_____
_____

What is that worth to you?
_____
_____

8 INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

_____

Printed name of Patient or Representative

x_____ _____

Signature of Patient or Representative Date

9 RECEIPT OF PRIVACY NOTICE

My signature, below, certifies that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

x_____ _____

Signature of Patient or Representative Date