Sonak Family Chiropractic
www.drwill.net

New Patient Information

Welcome to our office: Please allow our staff to photocopy your insurance card.

PLEASE PRINT CLEARLY.

Full Name: _____ **Nickname:** _____

E-mail: _____ **Gender**: ☐M ☐F **Age**:_____ **Birth Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security#: _____-_____-_____ **Insurance Carrier:** _____ **Who is the insured?**_____

Home Phone: (____) _____ **Cell Phone**: (____) _____

Marital Status: ☐S ☐M ☐D ☐W **# of Children**:____ **Names and ages (under 22):**_____

Work Status: ☐Full time ☐Part-time ☐Retired

Employer: _____ **Occupation**: _____ **Work Phone**: (____) _____

Employer Address: _____ **City**: _____ **State**:_____ **Zip**: _____

Females: Last Menstrual Period: _____ **Pregnant?** ☐Y ☐N **If Yes, name of midwife or OB**:_____

If yes, expected date of delivery:_____ **Nursing?** ☐Y ☐N

Name of Spouse, Parent or Guardian: _____ **Age**: _____ **Birth Date**: _____ **SS#:** _____-_____-_____

Spouse's Employer: _____ **Spouse's Occupation**: _____ **Work Phone**: (____) _____

In case of an Emergency Contact: _____ **Relationship**: _____

Home Phone: (____) _____ **Cell Phone**: (____) _____ **Work Phone**: (____) _____

How did you hear about our clinic? Whom may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Sonak Family Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Sonak Family Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1) _____
2) _____
3) _____
4) _____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: ☐Y ☐N

If yes, whom? _____ Treatment(s):_____

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐Gradually worse

How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night only How long does it last? ☐All day ☐Few hours ☐Minutes

Is this condition interfering with your: ☐Work ☐ Sleep ☐Daily routine ☐Recreation ☐Other : _____

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐ >10 years

Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: _____

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: _____

Is there anything that you can do to relieve the problem? ☐Y ☐N If yes, describe: _____

If no, what have you tried to do that has not helped?_____

What do you believe is wrong with you? _____

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N If yes, what? _____

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

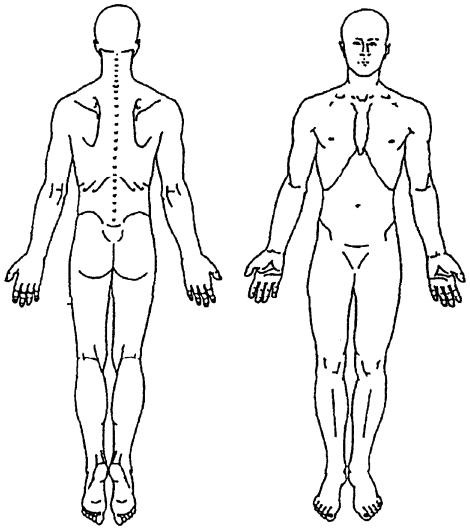
Describe: _____

Please check all of the symptoms that apply. (**C**= Current / **P**= Past)

C / P	C / P	C / P
☐ ☐ Headache	☐ ☐ High Blood Pressure	☐ ☐ Tingling in Feet
☐ ☐ Facial Pain	☐ ☐ Low Blood Pressure	☐ ☐ Walking Problems
☐ ☐ Eye Pain	☐ ☐ Abdominal Pains	☐ ☐ Sore Muscles
☐ ☐ Blurred Vision	☐ ☐ Nausea/Vomiting	☐ ☐ Weak Muscles
☐ ☐ Dizziness	☐ ☐ Poor Appetite	☐ ☐ Paralysis
☐ ☐ Earache	☐ ☐ Fullness of Bladder	☐ ☐ Shakiness
☐ ☐ Forgetfulness	☐ ☐ Urination Difficulty	☐ ☐ Sweating
☐ ☐ Confusion	☐ ☐ Frequent Urination	☐ ☐ Insomnia
☐ ☐ Sinusitis	☐ ☐ Constipation	☐ ☐ Fainting
☐ ☐ Teeth Grinding	☐ ☐ Hemorrhoids	☐ ☐ Convulsions
☐ ☐ Dry Mouth	☐ ☐ Decreased Sex Drive	☐ ☐ Irritability
☐ ☐ Excessive Thirst	☐ ☐ Menstrual Irregularities	☐ ☐ Impatience
☐ ☐ Unpleasant Taste	☐ ☐ Elbow / Hand Pain	☐ ☐ Fatigue
☐ ☐ Neck Pain	☐ ☐ Tingling in Hands	☐ ☐ Feel Loss of Control
☐ ☐ Sore Throat	☐ ☐ Clammy Hands	☐ ☐ Other:_____
☐ ☐ Lump in Throat	☐ ☐ Low Back Pain	_____
☐ ☐ Swallowing Pain	☐ ☐ Hip Pain	
☐ ☐ Unsteady Voice	☐ ☐ Knee Pain	
☐ ☐ Shoulder Pain	☐ ☐ Poor Circulation	
☐ ☐ Persistent Coughing	☐ ☐ Swollen Joints	
☐ ☐ Chest Pressure	☐ ☐ Joint Stiffness	
☐ ☐ Slow Heart Rate	☐ ☐ Swollen Ankles	
☐ ☐ Rapid Heart Rate	☐ ☐ Ankle / Foot Pain	

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - lll
Burning - XXX
Numbness - ===
Tingling - :::
Cramping - ^^^
Dull - ###



ALLERGIES: Please check and list all allergies.

☐ Food: _____

☐ Medications: _____

☐ Seasonal / Other:_____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had. _____

_____

_____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? _____

HABITS:

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	_____	_____

	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2
Meals / day	☐	☐	☐	☐

	64+ oz	32-64 oz	16-32 oz	<8 oz
Water / day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**G =** Grandparents, **M =** Mother, **F =** Father, **S =** Siblings, **X** = Self)

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Detached retina
___Diabetes
___Eczema
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart disease
___HIV / AIDS
___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic fever
___Stroke
___Tumor(s)
___Ulcer(s)
___Other: _____
_____
_____

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)