Beaufort Chiropractic

New Patient Health Form

In order to provide you the best possible wellness care, please complete form in full.
All information is strictly CONFIDENTIAL

Personal Information

Date:

First Name:	Last Name:	
Address:		
City:	State:	Zip:
Phone: (H)	(C)	Preferred method of contact:
Email:		
Birthdate:	Age:	
Marital Status:	Number of Children:	
Occupation:		
Employer:		
Known medical conditions:		
Known allergies:		
Emergency Contact:	Contact Number:	Relationship:

Reason For Today's Visit:

Date of Injury:	Nature of Injury: ☐ Automobile ☐ Work ☐ Other	
Please describe:		
Date symptoms appeared:		
Have you had x-rays taken?	If yes, where?	
Ever had this condition before?		
Other practitioners seen for this injury/condition:		
Have you ever had chiropractic care, physical therapy, massage and/or acupuncture? If yes, please describe:		
Date of last physical exam:		
Is there a chance that you are pregnant?		
What are your expectations for seeking chiropractic care?		

Please Rate Your Level of Pain: (0=no pain, 10=severe pain)

0	1	2	3	4	5	6	7	8	9	10

22 Professional Village Cir., Beaufort, SC 29907
www.BeaufortChiropracticCare.com

Beaufort Chiropractic

Medical History:

What medications are you taking and for what conditions (Please list dosage/amounts)
What vitamins, minerals, herbs do you take? (Please list for what conditions dosage/frequency)
Have you been treated for ANY conditions in the last year? If yes, please describe.

Have you ever:	**Yes**	**No**	**If yes, briefly explain**
Broken any bones?			
Been hospitalized?			
Been in an auto accident?			
Had Sprains/Strains?			
Been struck unconscious?			
Had surgery?			
Had a concussion?			

Family Health History – Parents, Grandparents, Siblings (ex. heart disease, cancer, etc.)
Past and present conditions

Beaufort Chiropractic

Please Answer the Following Questions:

	Yes	No
Do you experience pain every day?		
Does your pain interfere with daily life?		
Does your pain wake you up at night?		
Is pain worse during certain times of the day? If yes, briefly explain:		
Do changes in weather affect your pain? How?		
Do you have regular bowel movements? How many per day?		
What makes you feel better?		
What makes the pain worse?		

Indicate Intake/Amount of:	Yes	No	How much/describe
Alcohol			
Coffee			
Tobacco			
Drugs (any type)			
Exercise			
Appetite			
Soft Drinks			
Water			
Salty Foods			
Sugary Foods			

Please Answer the Following Questions:

Is stress a major problem for you?
How do you deal with stress?
Do you feel depressed?
Do you panic when stressed?
Do you cry frequently?
Do you have problems with appetite or eating?
Have you ever attempted suicide?

22 Professional Village Cir., Beaufort, SC 29907
www.BeaufortChiropracticCare.com

Beaufort Chiropractic

Ever thought of seriously hurting yourself?
Have you ever been to a counselor or therapist?
Do you have any issues with your memory?
Do you ever get “foggy” brain or “fuzzy” thinking?
Any recent changes in weight?
Any recent changes in your energy level?
Do you often experience headaches or migraines?
Please describe any other pain or discomfort:

Your Sleep Habits:

Any recent changes in your ability to sleep?
What time do you usually go to bed?
What time do you usually wake up?
Any issues falling or staying asleep?
Any issues getting up, getting going, or feeling rested in the morning?
Do you take any medication or supplements to help you sleep? If yes, what?
What position do you sleep in? (back, left side, right side, stomach, all over)
Do you have frequent falls?
Any hearing or vision issues?
Do you live alone?
Have you had any dizzy spells?
Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue?

Beaufort Chiropractic

Check All that Apply to You (Past & Present)

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Back pain
- ☐ Bad breath
- ☐ Birth trauma
- ☐ Black, tarry Stools
- ☐ Bladder disease
- ☐ Blood clots
- ☐ Blood disease
- ☐ Blood in urine
- ☐ Bone disease
- ☐ Bowel disorder (loose stools/diarrhea/constipation)
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chest pain/conditions
- ☐ Cold extremities
- ☐ Cramps
- ☐ Decreased urinary flow
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Digestion problems
- ☐ Discharge from breast
- ☐ Ears ringing
- ☐ Endocrine disease
- ☐ Excessive menstruation
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Eye pain or difficulties
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Gallbladder disease
- ☐ Gas/bloating/belching
- ☐ Genital sores or discharges
- ☐ Hardening of arteries
- ☐ Headaches/Migraines
- ☐ Hemorrhoids
- ☐ High cholesterol
- ☐ High/low blood pressure
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Irregular heartbeat
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Loss of memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps in breast
- ☐ Lung disease
- ☐ Male reproductive disorder(s)
- ☐ Mood swings
- ☐ Musculoskeletal disorder(s)
- ☐ Nausea/vomiting
- ☐ Neck pain or stiffness
- ☐ Nervousness
- ☐ Neurological disorders
- ☐ Nosebleeds
- ☐ Numbness/tingling
- ☐ Pacemaker
- ☐ Painful urination
- ☐ Polio
- ☐ Poor hearing
- ☐ Poor posture
- ☐ Prostate trouble
- ☐ Psychological/psychiatric disorder
- ☐ Rashes
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus infection
- ☐ Skin disorders
- ☐ Spinal curvatures
- ☐ Stomach disorder(s)
- ☐ Stress/tension
- ☐ Stroke
- ☐ Swelling of abdomen
- ☐ Swelling of hands/feet/ankles
- ☐ Swollen joints
- ☐ Tenderness/swelling in calf or thigh
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins
- ☐ Venereal disease
- ☐ Vision problems
- ☐ Visual floaters
- ☐ Weakness
- ☐ Other _____

Beaufort Chiropractic

Late Arrival/No Show Policy:

Our office runs on appointments, and we make every effort to be on time. Late arrivals and patients failing to show for their scheduled appointments can create problems for practitioners and patients. These problems, coupled with the unpredictable nature of health care, makes it difficult to stay on schedule at times. **Patients arriving late to their scheduled appointments may be asked to reschedule at our discretion. Patients who do not show for their appointments will be charged a fee of $50.00.**

Cancellation Policy:

In consideration of our limited time and the needs of other patients, please give notice **at least 24 hours in advance** of your appointment should you need to cancel or reschedule.

Failure to provide notice 24 hours in advance will result in your being billed $50.00.

I, _____, have read and understand the above policies of this office, I acknowledge that failure to comply with these policies will result in the billing of the above prices.

Patient signature _____ Date _____

22 Professional Village Cir., Beaufort, SC 29907
www.BeaufortChiropracticCare.com

Beaufort Chiropractic

CONSENT FOR TREATMENT

Health care providers are required to advise patients of the nature of treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with chiropractic treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strain following treatment.
b. There have been rare, reported cases of disc injuries following cervical and lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous (bone) spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous (bone) and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms.

Musculoskeletal care contributes to your overall wellbeing. ***The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address
b. The nature of the treatment
c. The risks and benefits of that treatment
d. Any alternative to that treatment

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation.

I intend this consent to apply to all my present and future care with **Dr. Laurel Ann Sams, DC**.

Dated this _____ day of _____ 20_____

Patient Signature (or legal guardian): _____

Print Name: _____

22 Professional Village Cir., Beaufort, SC 29907
www.BeaufortChiropracticCare.com

Beaufort Chiropractic

HIPPA Consent/Authorization of Use & Disclosure of PHI/Notice of Privacy

Patient Name:_____ Date of Birth:_____

Authorization to Release Medical and Appointment Information

I give my permission to release any of my PHI (Protected Health Information) to the names below. Without this authorization, I will not be able to disclose any information about you, your appointment, your bill(s), or your treatment in my office to anyone but you, the patient, your insurance company, or referring/treating physician(s).

Name:	**Relationship to You:**	**Type of Information to Release** (All, Appointment, Treatment, Financial)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Information

May we contact you and leave information regarding appointments, treatment as well other pertinent medical information in the following methods listed below? ☐ Yes ☐ No

If Yes, Please Check All That Apply:

☐ Home Phone ☐ Answering Machine/Voicemail ☐ Work Phone ☐ Mail

☐ Cell Phone ☐ Text Message ☐ Email

_____ _____

Patient/Guardian Signature Date