Hatch Chiropractic & Wellness
New Patient Information

Date _____

Title: (Check one) □ Mr. □ Mrs. □Ms. □ Miss □ Dr. **Gender:** □ Male □ Female

First Name _____ **Middle Initial** _____ **Last Name** _____

Address _____

City _____ **State** ____ **Zip Code** _____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____

Cell Phone (_____) _____-_____ **Email** _____

May we contact you via email? Y N

Date of Birth _____/_____/_____ **Social Security Number:** _____-_____-_____

Marital Status: Single Married Other **FEMALE PATIENTS**: Are you pregnant? Y N

Emergency Contact Name _____**Phone** (_____) _____-_____

Do you have Health Insurance? Yes: _____ No: _____	If yes, would you like us to bill your insurance for you? Yes: _____ No: _____ **We bill all Medicare!	**Please note that for all insurance cases, our office will need a copy of your card, and a photo ID will be required.
Is this related to an accident?	Yes: _____ No: _____	AUTO WORK OTHER
Date of Injury:	Has a claim been filed? Yes: _____ NO: _____	Were you hospitalized? Yes: _____ No: _____
**If your current condition is due to an accident, please immediately inform the office staff so that we may properly assist you in your care. ☺		
Have you ever seen a Chiropractor? Yes: ___ No: ___	Who may we thank for your referral? _____	Have you recently had any X-Rays/MRIs? Yes: _____ No: _____

Inclement Weather Policy: Our policy is aligned with the Douglas County School District (DCSD). If schools in Douglas County are closed due to weather Hatch Chiropractic will also be closed.

We will be open regular hours when school start times are delayed.

For office use only

ACCT_____ CT_____ PWS _____ INS _____ PIN _____ WPC_____ TYPC____

Patient Name_____**Date**_____

Medical Conditions: (Circle all that apply to you)

□ Arthritis □ Cancer □ Diabetes □ Heart Disease
□ Hypertension □ Psychiatric Illness □ Skin Disorder □ Stroke
□ Other _____

Surgeries: (Circle all that apply to you)

□ Appendectomy Cardiovascular procedure □Cervical spine □ Hysterectomy
□ Joint Replacement Prostate □ Lumbar spine □ Gall Bladder
□ Brain Shoulder □Thoracic spine □ Knee
□ Carpal Tunnel Gastro-intestinal □ Uro-genital □ Hernia
□ Other _____

Allergies: (Circle all that apply to you)

□ Eggs □ Fish and Shellfish □ Milk or Lactose □ Peanuts
□ Soy Sulfites □ Wheat/Glutens □ Other _____

Social History			
Caffeine use	Occasional	□ Often	□ Never
Drink Alcohol	Occasional	□ Often	Never
Exercise	Occasional	□ Often	□ Never
Chew Tobacco	Occasional	□ Often	□ Never
Cigarettes	<1 pack/day	□ >1 pack/day	□ Never
Wear Seat Belts	Occasional	□ Always	□ Never

Family History		
Arthritis □	Parent □	Sibling
Cancer □	Parent □	Sibling
Diabetes □	Parent □	Sibling
Heart Disease □	Parent □	Sibling
Hypertension □	Parent □	Sibling
Stroke	Parent □	Sibling
Thyroid □	Parent □	Sibling

Patient Name_____**Date**_____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											

Please list all current medications being taken

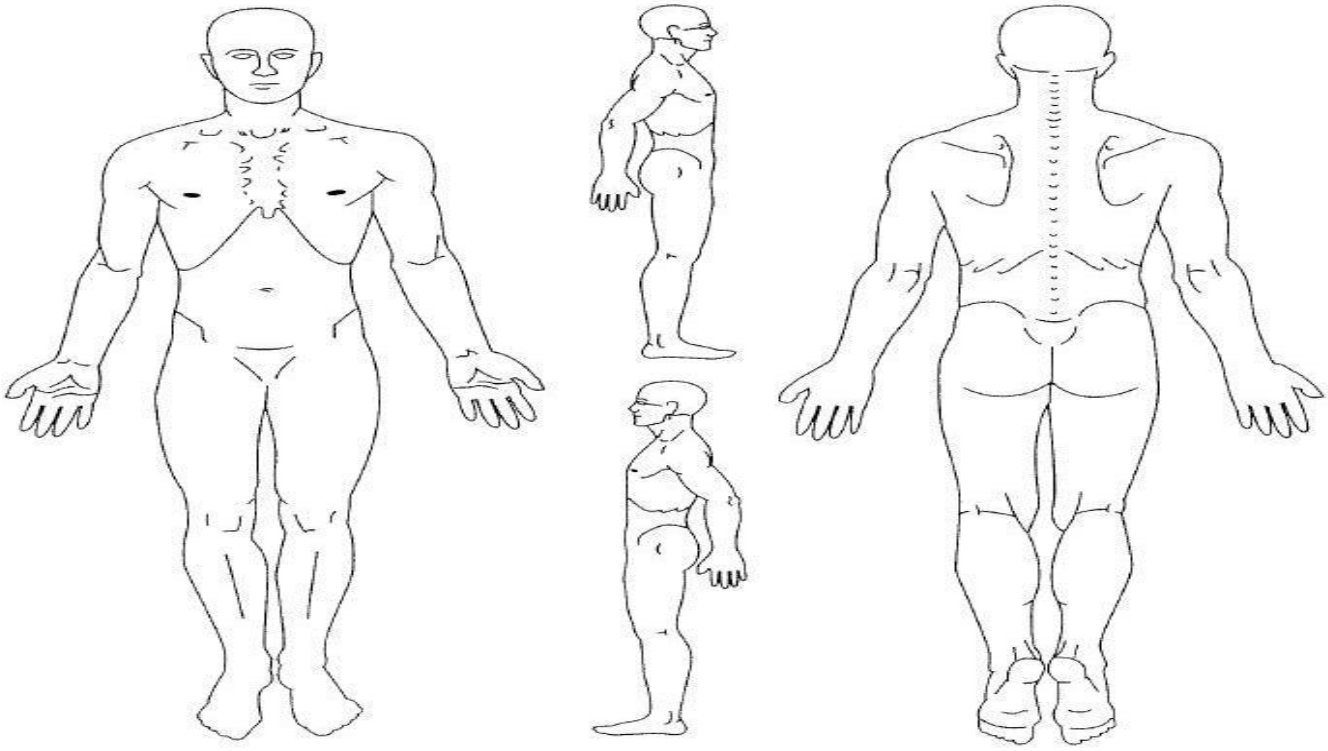
_____

_____

_____

Patient Name_____**Date**_____

Indicate on the body diagram where you are experiencing symptoms:



Please describe, in detail, any issues that you wish to discuss with the Doctor today

_____

_____

_____

When did your symptoms begin? **Month**_____ **Day**_____ **Year** _____

How did your symptoms begin? _____

_____

How often do you experience your symptoms? Circle the one that best describes your symptoms

□ Constantly (76-100% of the day)	Frequently (51-75% of the day)	Occasionally (26-50% of the day)	Intermittently (0-25% of the day)

What describes your symptoms? Circle the one that best describes your symptoms

□ Sharp	□ Dull ache	□ Numb	□ Shooting
□ Burning	□ Tingling	□ Stabbing	□
Other _____			

How are your symptoms changing?

□ Getting better	□ Not changing	□ Getting worse

Patient Name_____**Date**_____

Employment Status: Employed Unemployed Student Other_____

Employer Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Occupational Activities: (Circle the one that best describes your job description)

□ Administration	Business Owner	Clerical/Secretary	Computer User
□ Heavy Equipment operator	Daycare/Childcare	Construction □	Health Care
□ Food Service Industry	Medium Manual Labor	Manufacturing □	Home Services
□ Heavy Manual Labor □	Light Manual Labor	Executive/Legal □	Housekeeper

□ Other _____

Condition's Effect On Job Performance:

□ **No Effect** □ **Mild** (painful can do) □ **Moderate** (painful limited ability)
□ **Moderate/Severe** (limited duty) □ **Severe** (no/limited duty) □ **Extremely Severe** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Carrying Groceries:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sit to Stand:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Climb Stairs:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Driving:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Computer Use:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Household Chores:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Kneeling:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lift Children:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Lifting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Pet Care:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Concentration:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Self Care:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sexual Activities:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sleep:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Sitting:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Standing:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Walking:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform
Yard Work:	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (Limited)	□ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform
_____	□ **No Effect**	□ **Mild** Painful (Can do)	□ **Mod** Painful (limited)	□ **Sev** Unable to Perform

Patient Name_____Date_____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Chiropractic Office's Notice of HIPAA Privacy Practices for protected health information.

Patient's Signature_____

Consent to Treat a Minor: (Minor's Printed Name) _____

Parent/Guardian Signature Authorizing Care _____

Please Carefully Read the Following and Initial Each Statement

Office Policies:

_____ **Sign In:** When you arrive for your appointment please sign in with the front desk. This is required by law. If you have any changes in your condition, we ask that you please inform us at this time so that we can ensure proper treatment.

_____ **Payment of Bills:** Payment is required at time services are rendered. You will be expected to honor your financial agreements with our office. If you find that you cannot fulfill your financial agreement with our office, please immediately speak with our Office Manager to make new arrangements.

_____ **Cell Phones:** We ask that you refrain from using your cell phone while in the treatment areas. Please respect that there are other patients in the office.

_____ **Arbitration:** By my initials I consent to Arbitration rather than going to court as a way of resolving any future claim about my chiropractic care. This agreement applies only to the care that I receive in this office or out call service from Dr. Ryan Hatch or any associate doctor (past, present or future) working with Dr. Ryan Hatch and/or Hatch Chiropractic & Wellness, LLC.

_____ **Collections:** By my initials, I hereby waive my statute of limitations to any outstanding balance with this office. I understand that should my account become delinquent, Hatch Chiropractic & Wellness will give me reasonable opportunities to satisfy my financial obligations. I understand that should my account be sent to an outside collections agency, I will incur further charges.

I have read or have read to me the above policies and consents. By my signature below, I agree to all the above policies and statements.

_____ **Informed Consent:** I understand and am informed that, in the practice of Chiropractic care there are some risks involved. To exam and treat including, but not limited to, fractures, disc injuries, stroke, dislocations, sprains, increased symptoms of pain, no improvement of symptoms or pain and in extreme rare instances death can occur. I do not expect the Doctor to be able to anticipate and explain all the risks and complications, however I wish to rely on the doctor to exercise judgment during the procedure(s) which the Doctor feels at the time, based on information I have given him, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Patient Signature: _____ Date: _____

Signature of Legal Parent or Guardian: _____ Date: _____