New Patient Paperwork

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 Divorced 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: _____	**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 open at 10:00 AM when school start times are delayed.

Medical Conditions: (Check all that apply)

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

Surgeries: (Check all that apply)

□ Appendectomy □ Cardiovascular □ Cervical Spine □ Hysterectomy
□ Joint Replacement □ Prostate □ Lumbar Spine □ Gall Bladder
□ Brain □ Shoulder □ Thoracic Spine □ Knee
□ Carpal tunnel □ Gastrointestinal □ Urogenital □ Hernia
□ Cesarean Section #_____ □ Other _____

Allergies: (Check all that apply)

□ 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
Chew Tobacco	□ Occasional	□ Often	□ Never
Cigarettes	□ Occasional	□ Often	□ Never
Wear Seat Belts	□ Occasional	□ Often	□ Never
Marijuana Use	□ Occasional	□ Often	□ 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

Please list all current medications and OTC supplements being taken:

_____

_____

_____

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

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

Nutrition History

Have you made any changes in your eating habit because of your health?

If yes, please describe _____

Do you avoid any foods? □ Yes □ No

If yes, type and reason _____

Do you current follow a special diet or nutritional program? □ Yes □ No Check all that apply:

□ Low Fat	□ Low Carbohydrate	□ High Protein	□ Low Sodium
□ Diabetic	□ No Dairy	□ No Wheat	□ Gluten Restricted
□ Vegetarian	□ Vegan	□ Weight Loss	□ Other

Do you drink water? □ Yes □ No If yes, amount consumed in a 24-hour period _____

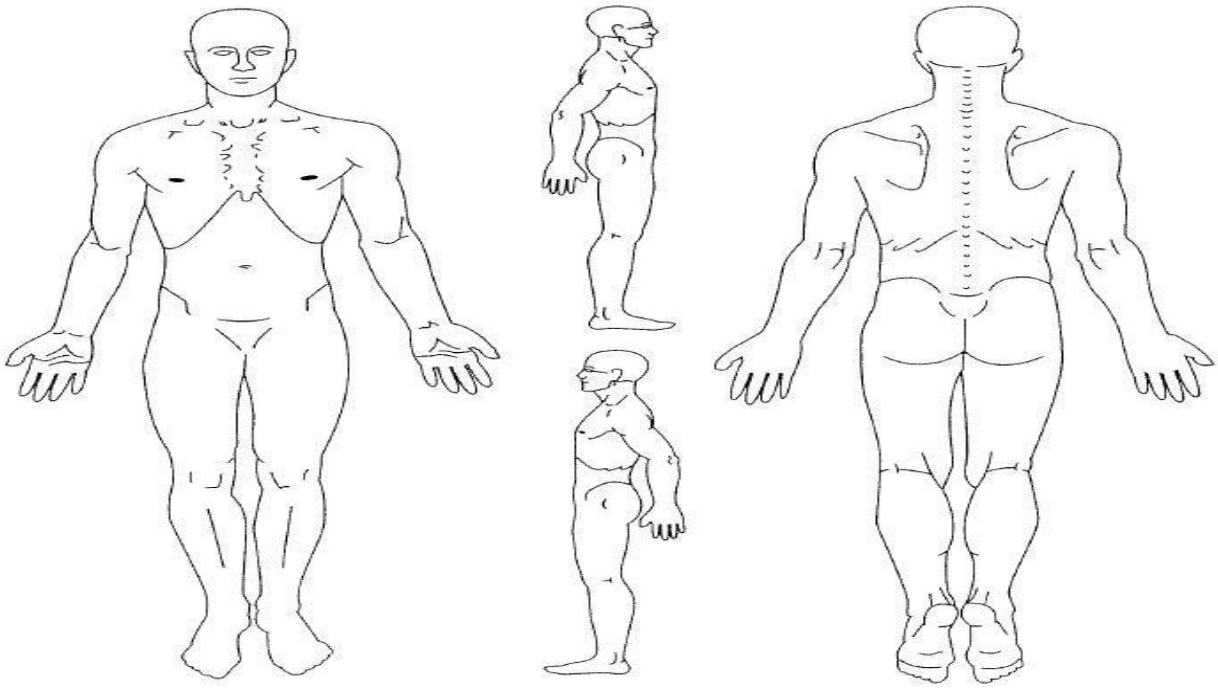
Do you exercise: □ Yes □ No If yes, how often _____

Nutrition History (continued)

Check all the factors that apply to your current lifestyle and eating habits:

□ Fast Eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% of meals away from home
□ Travel frequently
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience items
□ Emotional eater (eat when sad, lonely, depressed, bored)
□ Significant other or family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Poor snack choices
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

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 symptoms? Check the one that best describes your symptoms

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

What describes your symptoms? Check 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

Employment Status: Employed Unemployed Student Other_____

Employer Name _____

Address _____

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

Occupational Activities: (Check 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/Severe (limited duty)
Moderate (painful, limited ability) Severe (no/limited duty) Extremely Severe (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance – Please check applicable box

Bending	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Carrying Groceries	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Sit to Stand	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Climb Stairs	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Driving	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Computer Use	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Household Chores	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Kneeling	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Lift Children	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Pet Care	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Concentration	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Self-care	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Sexual Activities	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Sleep	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Sitting	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Standing	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Walking	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
Yard Work	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe

Recreational Activity: Effects of Current Condition on Performance

_____	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
_____	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe
_____	□ No Effect	□ Mild	□ Moderate	□ Severe	□ Extremely Severe

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. **Initials** _____

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 the 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 independent collection agency I will incur further charges.

_____ **Informed Consent:** I understand and am informed that, in the practice of chiropractic and acupuncture 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.

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.

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

Parent/Guardian Signature Authorizing Care _____

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Signature of Legal Parent or Guardian: _____ Date: _____