

**KARE CHIROPRACTIC**  
**New Patient Information**

Name \_\_\_\_\_  Female  Male Date \_\_\_\_\_

What you prefer to be called \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Preferred Language  English  Other \_\_\_\_\_ Race:  White  African American  Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ SS# \_\_\_\_\_

Preferred Method of Contact \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

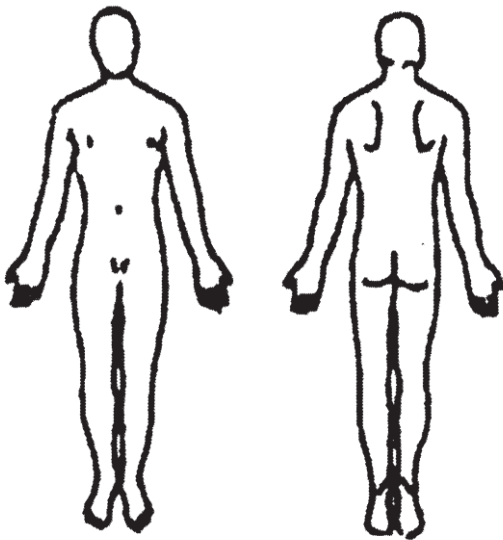
How did you hear about our office? \_\_\_\_\_

When did your condition begin? \_\_\_\_\_

Other Doctors seen for this condition? \_\_\_\_\_

Have you had the same or similar symptoms before?  Yes  No Date of prior condition \_\_\_\_\_

**Mark Areas of Pain on Figures Below** List chief symptoms in order of severity:



(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

Have you had chiropractic care before?  Yes  No

Family Physician \_\_\_\_\_

May we forward our findings to your doctor?  Yes  No

Current Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies (Medicine, Food, Environment) \_\_\_\_\_

\_\_\_\_\_

Previous Surgeries \_\_\_\_\_

Do you have a PERSONAL history of:  Cancer  Diabetes  Heart Disease  Stroke

Other serious illnesses \_\_\_\_\_

Check all symptoms that apply to you

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Tingling/numbness in arms/hands | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Unexplained Weight loss |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Tingling/numbness in legs/toes  | <input type="checkbox"/> Knee Pain               | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Loss of balance/dizziness       | <input type="checkbox"/> Hip Pain                | <input type="checkbox"/> Night Sweats            |
| <input type="checkbox"/> Shoulder            | <input type="checkbox"/> Shortness of breath             | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Blood in Urine          |
| <input type="checkbox"/> Other _____         | <input type="checkbox"/> Night Pain                      | <input type="checkbox"/> Pain unrelieved by rest |  |

For women: Are you pregnant?  Yes  No

Are you taking birth control?  Yes  No

**Health Insurance**

Policyholder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Workers Compensation**

Is your condition due to an Employment Related Injury?  Yes  No      Have you reported it?  Yes  No

Date of accident \_\_\_\_\_

Supervisor \_\_\_\_\_ Supervisor # \_\_\_\_\_

**Auto Accident**

Is your condition due to Automobile Accident?  Yes  No      Date of accident \_\_\_\_\_

Auto Accident Insurance Name \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster Name \_\_\_\_\_ Phone # \_\_\_\_\_

Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Nicholas Liford, DC, and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Kare Chiropractic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT TO TREAT A MINOR**

I (we) being the parent, guardian or custodian of the minor being \_\_\_\_\_, age \_\_\_\_\_, do hereby authorize, request & direct Kare Chiropractic, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Witness \_\_\_\_\_