New Patient Forms

In order to provide you with the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

First Name _____ Last Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Text Ok? _____ How did you find us? _____

Birth Date _____ Age _____ Email Address _____

Occupation _____ Employer _____

Number of Children _____ Marital Status _____

Spouse's Name _____ Spouse's Occupation _____

Emergency Contact Name _____ Emergency Contact Phone _____

Nature of Injury: ☐ Automobile ☐ Work ☐ Other

Please describe how the injury occurred:

_____

_____

Date of Injury _____ Date Symptoms Appeared _____

Name of Party Responsible for Payment _____ Phone _____

Do you have health insurance? ☐ Yes ☐ No Name of Company _____

Name of Insured _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date _____

Guardian's Signature _____ Date _____

Health History

Have you been treated for this same condition elsewhere? ☐Yes ☐No

If yes, please describe: _____

Have you had X-Rays taken? _____ If yes, where? _____

Have you been to a chiropractor before? ☐Yes ☐No If yes, where? _____

Date of last physical exam: _____ Is there a chance that you are pregnant? _____

Please list current medications you are taking and for what condition they are taken for:

Please list current vitamins, minerals, or herbs you are currently taking and condition they are taken for:

Have you ever:	No	Yes	If Yes, Briefly Explain
Broken bones?	☐	☐	
Been hospitalized?	☐	☐	
Been in an auto accident?	☐	☐	
Had sprains/strains?	☐	☐	
Been struck unconscious?	☐	☐	
Had surgery?	☐	☐	

Do you experience pain every day?	☐ No	☐ Yes
Do your symptoms interfere with daily life?	☐ No	☐ Yes
Does pain wake you up at night?	☐ No	☐ Yes
Are your symptoms worse during certain times of the day?	☐ No	☐ Yes
Do changes in weather affect your symptoms?	☐ No	☐ Yes
Do you wear orthotics?	☐ No	☐ Yes

What activities aggravate your symptoms? _____

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Does your family have a history of any serious conditions such as heart disease, cancer, diabetes, etc?
Please describe:

Have you ever suffered from:

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Loss of Memory
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Lumps in Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems/Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other:

Primary Concern:

_____Pain level 1-10 (10=worst) _____

Secondary Concern:

_____Pain level 1-10 (10=worst) _____

Other Concerns:

_____Pain level 1-10 (10=worst) _____

Please use the following letters to indicate type and location of the symptoms you currently are experiencing

A– Ache

B– Burning

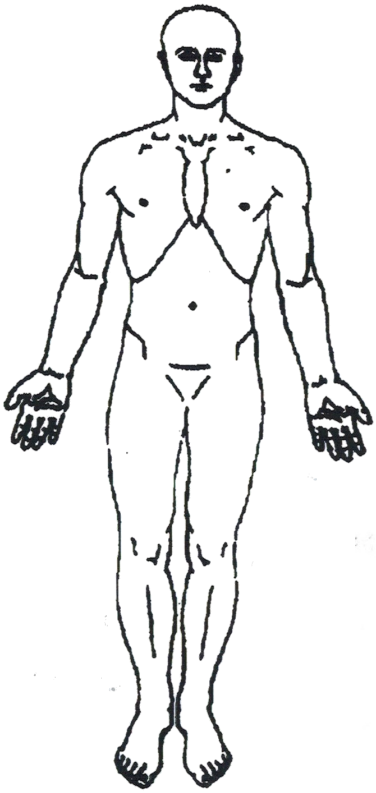
N– Numbness

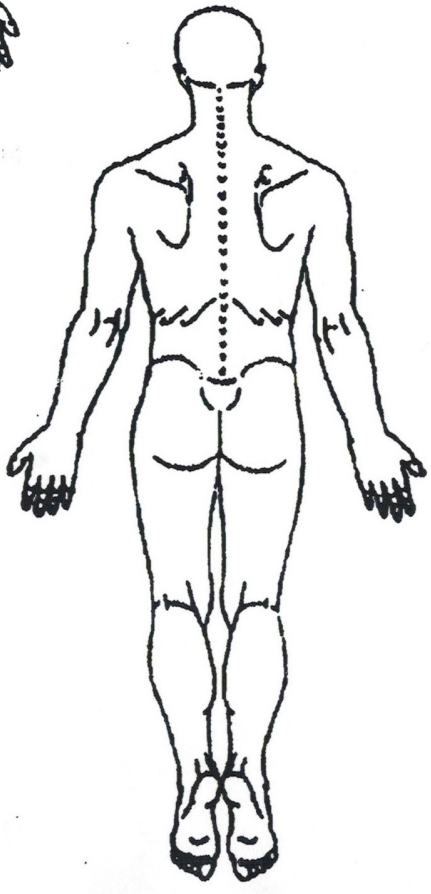
P– Pins & Needles

S– Stabbing

T– Tingling

O– Other (please specify)





INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the chiropractic services of Ace Chiropractic Clinic, associated licensed doctors and/or authorized persons who might now or in the future treat me while employed by, working or associated with, or serving as back up for Ace Chiropractic Clinic in an attempt to improve my physical condition.

I understand the purpose of this and subsequent visits are to acquire chiropractic care. A natural and conservative approach to my health needs, chiropractic care utilizes manipulation or joint adjustments, exercise, nutrition, and various modes of physiotherapy.

I understand that a definitive diagnosis may require further test (x-ray, laboratory test, MRI, etc.) and/or referrals to other health care professionals. Although Ace Chiropractic Clinic may prescribe or suggest these test or referrals, it is my responsibility to schedule an appointment and to acquire these test and/or referrals.

I understand and am informed that some risks are associated with chiropractic treatment, including, but not limited to, sprains, dislocations, fractures, disc injuries, stroke, burns, frostbite, and paralysis. I do not expect Ace Chiropractic Clinic to be able to anticipate and explain all risks and complications, but based on the facts then known, I wish to rely on his judgment during the course of the procedures, which he feels is in my current best interests.

The body's (nervous and musculoskeletal systems) reaction to Ace Chiropractic Clinic treatments may be generalized soreness over and around the area of chief complain. This is a normal and expected result because the muscles in the area have been stressed (spasm) and the bones misaligned. During my treatment, Ace Chiropractic Clinic will be releasing stress on the spine, bones, joints, and surrounding soft tissue (e.g. muscles, tendons, ligaments, bursae, and nerves). This process breaks up the pain and spasm cycle in the body, but in doing so, my body may require time to adjust to these physiological changes.

I understand that I am responsible for monitoring my own condition throughout the treatment and will inform Ace Chiropractic Clinic of any unusual symptoms that may occur.

In signing the informed consent form, I affirm that I have read this form in it entirely and that I understand the nature of the chiropractic treatment. I also affirm that all my questions regarding the chiropractic treatment, the management of my case and the related risk of chiropractic treatment have been answered to my satisfaction.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Patient Name (printed) : _____

Patient or Guardian Signature: _____

Date: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic name below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that. As in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing and surger. I understand and have been informed that I have a right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Chiropractor Name:_____

Patient Name:_____

Patient or Guardian Signature:_____Date:_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: it is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were unauthorized, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: it is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouses of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care providers clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care providers associates, association, cooperation, partnership, employees, agents, and estate must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator within thirty days and a third arbitrator shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request of the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would be a proper additional party in a court action, upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (civil code 3333.1) the limitation on recovery for non-economic losses (civil code 3333.2) and the right to have a judgment for future damages conformed to periodic payments (ccp 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to the arbitration agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the application legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: the agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: if patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here._____ Effective as the date of first professional services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE; BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient or Guardian Signature: _____ Date: _____

Office Signature: _____ Date: _____