namaste CHIROPRACTIC

CHIROPRACTIC
5540 PGA Boulevard
Suite 100
Palm Beach Gardens, Florida 33418
www.namastechiropractic.com
office: 561-619-7319
fax: 561-619-7325

New Patient Information Form

Welcome!

How did you hear about us? _____

Please provide us with the following information:

Patient First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code _____

Mobile Phone: _____

Email: _____ Alternate Phone: _____

Out-of-State Address (*if applicable*): _____

City: _____ State: _____ Zip Code: _____

Number of Children & Ages: _____

Sex: Male Female Other

Marital Status: Married Single Domestic Partner Widowed

Date of Birth: _____ Age: _____

Employment: Part Time Retired Unemployed

Employer: (*if applicable*) _____ Occupation: _____

INSURANCE INFORMATION *(if applicable)*

Primary Insurance Company Name: _____

Secondary Insurance Company Name: _____

In the event Namaste Chiropractic is not reimbursed by patient's insurance company, patient agrees to fulfill financial obligation in full.

Patient Signature: _____

COMPLAINTS – Please tell us the reason(s) for your visit today:

Complaint #1: (Circle one)	Neck Pain Mid-Back Pain Low-Back Pain	Shoulder Pain Hip Pain Knee Pain	Elbow Pain Other _____	**Date this began?** / /

Pain Rating 1 – 10 *(worst)*	1	2	3	4	5	6	7	8	9	10

Pain Description	Aching	Sharp	Dull	Burning	Throbbing	Electric
		Tingling	Deep	Shooting	Stabbing	

Experienced in past? Yes No

What treatment(s) have you tried?

Chiropractic Care	Physical Therapy	Acupuncture	Medical Doctor
Steroid Injection	Regenerative Medicine	Platelet Rich Plasma (PRP)	Stem Cell Therapy
Other Injection	Surgery		

Complaint #2: (Circle one)	Neck Pain Mid-Back Pain Low-Back Pain	Shoulder Pain Hip Pain Knee Pain	Elbow Pain Other _____	**Date this began?** / /

Pain Rating 1 – 10 *(worst)*	1	2	3	4	5	6	7	8	9	10

Pain Description	Aching	Sharp	Dull	Burning	Throbbing	Electric
		Tingling	Deep	Shooting	Stabbing	

Experienced in past? Yes No

What treatment(s) have you tried?

Chiropractic Care	Physical Therapy	Acupuncture	Medical Doctor
Steroid Injection	Regenerative Medicine	Platelet Rich Plasma (PRP)	Stem Cell Therapy
Other Injection	Surgery		

Complaint #3: (Circle one)	Neck Pain Mid-Back Pain Low-Back Pain	Shoulder Pain Hip Pain Knee Pain	Elbow Pain Other _____	**Date this began?** / /

Pain Rating 1 – 10 *(worst)*	1	2	3	4	5	6	7	8	9	10

Pain Description	Aching	Sharp	Dull	Burning	Throbbing	Electric
		Tingling	Deep	Shooting	Stabbing	

Experienced in past? Yes No

What treatment(s) have you tried?

Chiropractic Care	Physical Therapy	Acupuncture	Medical Doctor
Steroid Injection	Regenerative Medicine	Platelet Rich Plasma (PRP)	Stem Cell Therapy
Other Injection	Surgery		

Have you sought chiropractic care in the past? Yes No

Chiropractor Name:_____ Date:_____ Reason:_____

Date of *last* spinal x-ray? _____ How long were you under care? _____

What other health care professionals have you consulted about your complaint(s) today?

1. _____ 3. _____
2. _____ 4. _____

MEDICATIONS

Please list *all* medications and/or supplements you are currently taking: ☐ **None**

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

Please list any other medications and/or supplements you are currently taking below:

ALLERGIRES

Are you allergic to any medications? **Yes** **No**

If yes, please list: _____

Are you allergic to SULFA drugs? **Yes** **No**

SURGERIES

Please list any previous surgeries and dates. *none*

_____

_____

LIFESTYLE

Do you smoke/vape? ☐ **Yes** ☐ **No**

Do you drink soda beverages? ☐ **Yes** ☐ **No**

Do you exercise regularly? ☐ **Yes** ☐ **No**

Do you have a pacemaker? ☐ **Yes** ☐ **No**

HISTORY

Please check all that you have experienced in the past 6 months:

GENERAL

- ☐ Headaches
- ☐ Dizziness
- ☐ Trouble Sleeping
- ☐ Depression
- ☐ Nervousness
- ☐ Anxiety
- ☐ Fainting
- ☐ Cancer _____

MUSCLES & JOINTS

- ☐ Neck Pain
- ☐ Mid-Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain ☐ L ☐ R
- ☐ Elbow Pain ☐ L ☐ R
- ☐ Hand/Wrist Pain ☐ L ☐ R
- ☐ Hip Pain ☐ L ☐ R
- ☐ Knee Pain ☐ L ☐ R
- ☐ Foot/Ankle ☐ L ☐ R
- ☐ Coccygeal Pain
- ☐ Migraines
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Bulging/Herniated Disk
- ☐ Flat Feet
- ☐ Numbness

EYES EARS NOSE & THROAT

- ☐ Earache ☐ L ☐ R
- ☐ Frequent Colds
- ☐ Poor Vision
- ☐ Ear Ringing ☐ L ☐ R
- ☐ Hay Fever
- ☐ Nose Bleeds
- ☐ Nasal Blockage
- ☐ Pain Behind Eyes
- ☐ Sinusitis
- ☐ Thyroid
- ☐ Sore Throat
- ☐ Tonsillitis

RESPIRATORY

- ☐ Asthma
- ☐ Spitting Blood
- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Difficulty Breathing
- ☐ Wheezing

CARDIO-VACULAR

- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Trouble
- ☐ Stroke
- ☐ Chest Pain
- ☐ Rapid Heart
- ☐ Swollen Ankles
- ☐ Varicose Veins

GASTRO-INTESTINAL

- ☐ Belching/Gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Frequent Nausea
- ☐ Poor Appetite
- ☐ Colon Problems
- ☐ Excessive Hunger
- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Poor Digestion
- ☐ Bloody Stool
- ☐ Excessive Thirst
- ☐ Liver/Gallbladder
- ☐ Ulcer
- ☐ Vomiting
- ☐ Weight Loss/Gain
- ☐ Vomiting Blood
- ☐ Diabetes
- ☐ Hypoglycemia

GENITO-URINARY

- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ Kidney Stones
- ☐ Frequent Urination
- ☐ Prostate
- ☐ Kidney Infection
- ☐ Urgency

SKIN & ALLERGIES

- ☐ Boils
- ☐ Eczema/Rash/Dermatitis
- ☐ Sensitive Skin
- ☐ Bruising Easily
- ☐ Hives
- ☐ Allergy: _____
- ☐ Dryness
- ☐ Itching

FEMALES

- ☐ Birth Control
- ☐ Cramps
- ☐ Breast Pain
- ☐ Hormone Replacement
- ☐ Hot Flashes
- ☐ Painful Periods
- ☐ Cramps/Backaches
- ☐ Irregular Periods
- ☐ Breast Implants

***Female Patients*:** *Is there a possibility of a current pregnancy?* ☐ Yes ☐ No

Patients often visit chiropractors to reach one of two objectives concerning their healthcare. Some patients seek symptomatic relief of their pain or discomfort, also known as "***relief care***". Others are interested in discovering the cause of their problem and set goals towards correcting and relieving their problem, known as "***corrective care***".

RELIEF CARE	**CORRECTIVE CARE**
Relief care gets rid of symptoms or pain, but not the cause of the problem. The initial problem is likely to return with more damage.	Corrective care differs from relief care in that the goal is to get rid of symptoms AND correct the cause of the problem.

Please check your desired type of care: ☐ Relief Care ☐ Corrective Care ☐ Not Certain

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Do You Suffer from JOINT Pain?

Is your day-to-day a little less enjoyable due to your chronic joint pain?

Namaste Chiropractic offers cutting edge technologies that ***work with your body's natural functions*** to help supplement and provide support where it's needed. If you'd like to learn more about our ***non-surgical***, Regenerative Medicine treatments in the office, please check the box below and we will contact you to learn more.

- ☐ I am interested in learning more about Regenerative Medicine and how it may apply to condition.
- ☐ I am interested in learning more about Human Cellular Tissue Products.
- ☐ I am interested in learning more about Platelet Rich Plasma (PRP).

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Treatment Consent Form

Consent for Treatment

I hereby give my consent for Namaste Chiropractic to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) such as:

- release of information to family physicians and employer
- release of information to insurance companies
- taking photographs and x-rays to be used for treatment purposes
- perform other diagnostic and therapeutic procedures for treatment purposes

I authorize my insurance benefits to be paid directly to:

Namaste Chiropractic
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561-619-7319

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, fees for professional services rendered me will be IMMEDIATELY due and payable. I agree that I will be responsible for all attorney a legal fees if legal action becomes necessary to collect unpaid debts.

Payment Policies

PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.

At the completion of your first office visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Consent to Treatment of Minor Child (*if applicable*)

I hereby authorize Namaste Chiropractic to administer treatment as they so deem necessary to my son/daughter/other,

_____ .
(Print Patient Name)

_____ _____
(Parent or Guardian Signature) (Date)

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TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE

When a patient seeks health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal: to eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine. Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation.
However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I_____ have read and fully understand the above statement.
(*print name*)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

_____ _____
(*patient signature*) (*date*)

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NOTICE OF PRIVACY FORM

Please read and sign this document *only* after you have read the

HIPAA Notice of Privacy Practices

located on the Namaste Chiropractic website under the "Patient Center" tab or you have viewed this form in our office.

Receipt of Notice of Privacy Practices Written Acknowledgment Form

Namaste Chiropractic

I, _____ have read a copy of Namaste Chiropractic's Notice
(*print patient name*)

of Patient Privacy Practices.

_____ _____
(Signature of Patient or Parent or Legal Guardian) (*Date*)

Who may Namaste Chiropractic have permission to speak with about your chiropractic health care?

NAME	RELATIONSHIP	PHONE NUMBER

How may we contact you? *Check all that to apply.* (*We value your privacy and never share or sell information with any 3rd parties.*)

- ☐ Phone
- ☐ Text
- ☐ Email

If you would like to retain a hardcopy of the HIPAA NOTICE of PRIVACY PRACTICES, please print from our website or request a copy in our office.