1342 Northside Dr East
Statesboro, GA 30458
912.681.7746
www.newlifechiropractors.com

Confidential Patient Case History

Name: ____ Date: ______________

Address: ______________________________ City & State: ________________ Zip: ______

Home Phone: ____________ Cell: _____________ M___ F___ Birthdate: ________Age: _____

Social Security #: _____-____-_____ Marital Status: __________________ # of Children: ________

Occupation: ___________________________ Employer: ___________________________

Spouse's Name: ____________________________________ Cell:____________________

How did you hear about our office: ___________________Referred by: _____________________

How long has it been since you felt good? ____

List Previous Doctors seen for present condition(s): ______________________________________

List any Allergies: ____

Type of care you desire? 1. **Crisis Care**: Relieve Symptoms 2. **Transitional Care**: Relieve Symptoms + Regain Function

3. **Peak Performance Care**: Relieve Symptoms + Restored Function + Maintain Function and Health.

Please use the corresponding letter to indicate any of the following symptoms which you have NOW or have had PREVIOUSLY
Those that don't apply leave blank:

O - Occasional F - Frequent C - Constant

____ Anxiety
____ Panic Attacks
____ Allergies
____ Dizziness/Vertigo
____ Fainting
____ Fatigue
____ Headache
____ Migraines
____ Loss of Sleep
____ Weight Gain
____ Loss of Weight
____ Nervousness
____ Depression
____ Numbness, Tingling
____ Tremors
____ Arthritis-Osteo
____ Rheumatoid Arthritis
____ Osteoporosis
____ Foot Trouble
____ Low Back Pain
____ Neck Pain or Stiffness
____ Pain between Shoulders
____ Spinal Curvature
____ Swollen Joints
____ Seizures
____ Muscle Spasm-Cramps
____ AM
____ PM

____ Bloating Gas
____ Belching Gas
____ Colon Trouble
____ Constipation
____ Diarrhea
____ Difficult Digestion
____ Heartburn/Acid Reflux
____ Excessive Hunger
____ Gall Bladder Trouble
____ Hemorrhoids
____ Liver Trouble
____ Nausea
____ Pain over Stomach
____ Poor Appetite
____ Vomiting
____ Vomiting of Blood
____ Hearing Loss
____ Ear Noises
____ Thyroid Dysfunction
____ Ear Infection
____ Ear Ache
____ Boils
____ Bruise Easily
____ Dryness
____ Hives
____ Itchy
____ Skin Eruptions (rash)
____ Varicose Veins

____ Bed Wetting
____ Blood in Urine
____ Frequent Urination
____ Incontinence
____ Declined Libido
____ Impotence
____ Sexual Dysfunction

____ Kidney Infection
____ Kidney Stones
____ Painful Urination

____ Bladder Infection
____ Prostate Problems

____ Visual Disturbances

____ PMS
____ Excessive Menstrual Flow
____ Hot Flashes
____ Irregular Cycle
____ Menopausal Symptoms
____ Painful Menstruation
____ Vaginal Discharge

Pregnant: Y N
_________Date of last period
COVID Vaccine: Y N
How many Boosters?
____

____ Irregular Heartbeat
____ High Blood Pressure
____ Low Blood Pressure
____ Pain Over Heart
____ Rapid Heartbeat
____ Slow Heartbeat
____ Swelling of Ankles
____ Chest Pain
____ Chronic Cough
____ Difficulty Breathing
____ Shortness of Breath
____ Wheezing
____ Asthma
____ Sinus Infection
____ Congestion

Pain, Numbness & Tingling in:
____ Shoulders
____ Arms
____ Elbows
____ Hands
____ Hips
____ Legs
____ Knees
____ Feet

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

____ Smoking	____ Eczema	____ Heart Disease	____ Miscarriage
____ Alcoholism	____ Emphysema	____ Heart Attack	____ Multiple Scierosis
____ Anemia	____ Epilepsy	____ Diabetes	____ Fibromyalgia
____ Stress	____ Gout	____ Stroke	____ Venereal Disease
____ Cancer - if so, Where: ________________________			____ Ulcers

LIST CURRENT MEDICATIONS AND REASON PRESCRIBED:

1 ________________________ 7 ________________________

2 ________________________ 8 ________________________

3 ________________________ 9 ________________________

4 ________________________ 10 ________________________

5 ________________________ 11 ________________________

6 ________________________ 12 ________________________

Do you use DIET foods, sodas, etc.? YES ______ NO ______

CIRCLE SURGERIES or hospitalizations you have undergone:

Angioplasty, heart by-pass, pacemaker, tonsillectomy, gall bladder removal, appendectomy, fracture, back, knee surgery, hip surgery, hysterectomy - partial or complete, breast augmentation

LIST ANY OTHERS:

________________________ ________________________

________________________ ________________________

________________________ ________________________

Have you been in an auto accident: Past year _____ Past FIVE years _____ OVER Five years _____ Never _____

Please Describe: ________________________

____

____

Is this visit a Workman's Compensation or Personal Injury Case? ________________________

Have you ever had previous CHIROPRACTIC care? YES _____ NO ______

If yes, date of last care: ________________

IN CASE OF EMERGENCY, PLEASE CONTACT: (Name of relative or close friend not living in your home)

NAME: ________________________

ADDRESS: ________________________

PHONE: ________________________

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Patient Intake Form

Informed Consent:

I hereby authorize physicians and staff at New Life Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the information I have given is correct to the best of my knowledge. I will not hold my doctor or any staff member of New Life Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as will any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in the office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is normal and an acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns – Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Patient's Signature: *(parent, if minor)* ___________________________________ Date: _______________

I understand and agree to allow this office to use Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Patient's Signature: *(parent, if minor)* ___________________________________ Date: _______________

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Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule." The Privacy Rule was created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment or payments, in order to provide health care that is in your best interest.

We may desire to use photographs taken of you by our office for treatment, educational, and/or advertising purposes. However, prior to using any photographs for advertising purposes we will obtain consent from patient, parent, or legal guardian.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information.

If you have any objections to this form, please ask to speak to one of our doctors.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Informed Consent for Photograph

Date: ___________________

I, _____________________________, due hereby give consent for Dr. Rachael, Dr. John, and staff
Legal Guardian

to take and/or display photograph(s) of the face and/or body of _________________________
Patient's Name

The photograph will be used for educational and/or advertising purposes by New Life Chiropractic and may be displayed within our office, advertising events, Facebook page at New Life Chiropractic Statesboro, and/or on the office's webpage, www.newlifchiropractors.com. The doctors, office and staff will protect the patient's personal data, such as name, age, and date of birth, from being displayed.

Print Name: ____________________________ Signature: _______________________________

Legal Guardian__________________________ Signature: _______________________________

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES / NO
May we leave a message on your answering machine at home or on your cell phone? YES / NO
May we discuss your medical condition with any member of your family? YES / NO

If YES, please name the members allowed:

____
Name Relation

____
Name Relation

____
Name Relation

This consent was signed by: ____(PRINT NAME PLEASE)

Signature: ____ Date: ________________

Witness: ____ Date: ________________

NEW LIFE CHIROPRACTIC & FUNCTIONAL NEUROLOGY

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Stress Survey

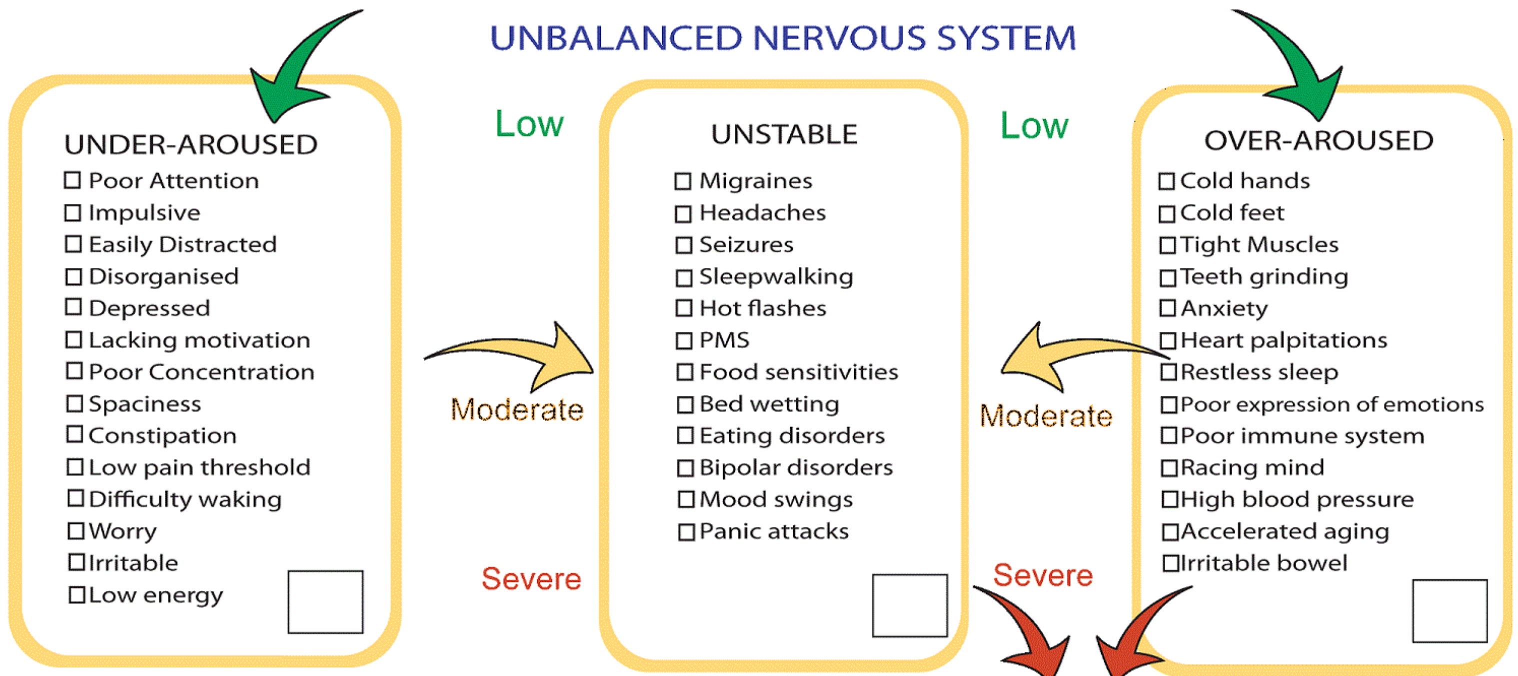
Name: ______________________________ Age:___ Cell:_______________ Email:_____________________
Address:_________________________ City:___________________ State:______ Zip Code:_______________
Occupation:____ # Hours/week currently working:________

On a scale of 1-10 (1 being no stress and 10 being extreme stress) please rate your daily stress levels:
Physical Stress: _________Chemical Stress:_________ Mental/Emotional Stress:_______

Please check off any of the following symptoms you may have experienced in the past 6 months, even if they seem unrelated to your current problem, and check the box where you fit on the chart:

BALANCED NERVOUS SYSTEM

☐High Energy ☐Few Symptoms ☐Resistant to Infections ☐Positive Mental Attitude
☐Mentally Alert ☐Excellent Health ☐Active ☐Vibrant ☐



EXHAUSTED NERVOUS SYSTEM

☐ Cancer ☐Rheumatoid Arthritis ☐Diabetes ☐Multiple Sclerosis ☐Depression
☐ Chronic Fatigue Syndrome ☐Fibromyalgia ☐ALS ☐ Epstein-Barr Syndrome ☐

According to the Centers for Disease Control and Prevention, up to 90 percent of the doctor visits in the USA may be triggered by a stress-related illness.

NEW LIFE CHIROPRACTIC
& FUNCTIONAL NEUROLOGY

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First Complaint:	Second Complaint:	Third Complaint:
Location of Complaint: Right/Left/Both	Location of Complaint: Right/Left/Both	Location of Complaint: Right/Left/Both
When did it start:	When did it start:	When did it start:
What aggravates the complaint:	What aggravates the complaint:	What aggravates the complaint:
What relieves the complaint:	What relieves the complaint:	What relieves the complaint:
How often is the complaint felt: Comes and Goes/Constant	How often is the complaint felt: Comes and Goes/Constant	How often is the complaint felt: Comes and Goes/Constant
When does it bother you most: Morning/Day/Night	When does it bother you most: Morning/Day/Night	When does it bother you most: Morning/Day/Night
Is the complaint getting: (circle one) Better/Worse/No Change	Is the complaint getting: (circle one) Better/Worse/No Change	Is the complaint getting: (circle one) Better/Worse/No Change
Pain Levels: (0=no pain, 10=go to ER) Current: /10 Worst: /10 Best: /10	Pain Levels: (0=no pain, 10=go to ER) Current: /10 Worst: /10 Best: /10	Pain Levels: (0=no pain, 10=go to ER) Current: /10 Worst: /10 Best: /10
Describe the complaint: Aching/Burning/Dull/Sharp/Sore/ Shock-like/Throbbing/Stabbing/ Numbness/Tingling/Weakness/Tight Stiff (circle all that apply) Other:	Describe the complaint: Aching/Burning/Dull/Sharp/Sore/ Shock-like/Throbbing/Stabbing/ Numbness/Tingling/Weakness/Tight Stiff (circle all that apply) Other:	Describe the complaint: Aching/Burning/Dull/Sharp/Sore/ Shock-like/Throbbing/Stabbing/ Numbness/Tingling/Weakness/Tight Stiff (circle all that apply) Other:
Is the complaint: Local/Does it Travel (circle one) If so where:	Is the complaint: Local/Does it Travel (circle one) If so where:	Is the complaint: Local/Does it Travel (circle one) If so where:
Does the complaint affect any of your daily activities: (ex. Driving a car)	Does the complaint affect any of your daily activities: (ex. Driving a car)	Does the complaint affect any of your daily activities: (ex. Driving a car)
Do you have headaches: Y N If so where (on the head):	Difficulty: falling asleep/ staying asleep / waking up tired & fatigued. Do you remember your dreams every night?	Bowel movements per day:
History of concussions: Y N If so, how many & date(s):	History of seizures? Y N If so, how often:	
Accidents/traumas:	Additional Notes (Is there anything else we need to know): Commitment to getting healthy: /10	

Goals (Drs use ONLY):