NEW LIFE CHIROPRACTIC & FUNCTIONAL NEUROLOGY

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: _____

Brain Tap Technologies
Brain Tap Light Therapy and wellness services are procedures that include stress reduction therapy, nutritional stress/wellness consultation and Light Therapy. I fully understand that utilizing a brain tap does not offer allopathic drugs, surgery, chemical stimulants, or any other conventional treatments.

In addition, it does not diagnose, treat or otherwise prescribe for my disease, illness, or perform any act that would constitute the practice of medicine for which a license is required.

I am fully aware and release BrainTap Technologies and New Life Chiropractic to perform Light therapy sessions, and other stress reduction protocols.

By signing below, I acknowledge that I have read and understand all parts of this waiver, that I had the opportunity to ask any questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and I am here on this and subsequent visit solely on my own behalf.
Patient Signature (or Legal Guardian):_____ Date: _____

Examination protocols:

New Life Chiropractic reserves the right to justify the need or lack of need for diagnostic imaging such as x-ray radiographic imaging.

Stress Response Evaluation (SRE) - The stress response evaluation is a test evaluating the reaction your nervous system has to a perceived emotional or physical threat, whether actual or imagined. Such a reaction includes increased heart rate, reduced hand temperatures, increased beta wave activity in the brain, adrenalin production and many other things.

Neurofeedback and NeuroInfiniti stress response evaluations do not treat any disease or illness or diagnose any disease or illness other than an imbalance of brain waves in the brain during stressed times and relaxation times.

Health is the ability of your body to respond to a stressor appropriately and recover all the systems to an ideal state within 90 seconds. If there is an inability to respond appropriately and recover from said stressor whether physically, chemically or emotionally; a tension is then created in the nervous system which then leads to symptoms.

What is Neuro feedback?
Neuro feedback is the opportunity for the nervous system to be trained to adapt to stressors by training the brain waves to be in their appropriate ranges.
Symptoms you may feel after a neuro feedback session are relaxation, tired, calm. Other symptoms may be irritable, anxious, or headaches are common side effects of neuro feedback. As these symptoms may be uncomfortable they are not classified as negative or detrimental.

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First Complaint: Location of Complaint: Right/Left/Both	Second Complaint: Location of Complaint: Right/Left/Both	Third Complaint: 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: (circle one) Comes and Goes/Constant	How often is the complaint felt: (circle one) Comes and Goes/Constant	How often is the complaint felt: (circle one) Comes and Goes/Constant
When does it bother you most: (circle one) Morning/Day/Night	When does it bother you most: (circle one) Morning/Day/Night	When does it bother you most: (circle one) Morning/Day/Night
Is the complaint: (circle one) Better/Worse/No Change	Is the complaint: (circle one) Better/Worse/No Change	Is the complaint: (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: (Driving a car, gardening)	Does the complaint affect any of your daily activities: (Driving a car, gardening)	Does the complaint affect any of your daily activities: (Driving a car, gardening)

Do you have headaches: Y / N If so where (on the head):	Do you have difficulty: falling asleep/ staying asleep / waking up tired & fatigued? (circle all that apply) Dreaming? Y / N	Accidents/traumas:
History of concussions: Y / N If so, how many & date(s):	Commitment level to getting healthy: /10	Bowel movements per day:
History of seizures? Y / N If so, how often:	Additional Notes (Is there anything else we need to know):	

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Goals (Drs use ONLY):

STRESS SURVEY

Name: _____ Age: ___ Cell: _____
Address:_____ City:_____ State:_____ Zip Code: _____
Occupation:_____ Email:_____

On a scale of 0 - 10 (0 = no stress and 10 = extreme stress), rate your daily stress levels for each stress below:

Physical Stress: _____
(slip/fall, injury, no exercise)

Chemical Stress:_____
(artificial sweeteners, hair dye, meds, pesticides, antiperspirant)

Mental/Emotional Stress:_____
(death, finances, worry)

In the past **6 months**, check any of the following boxes that apply:

Balanced Nervous System

- ☐ High Energy
- ☐ Excellent Health
- ☐ Few Symptoms
- ☐ Mentally Alert
- ☐ Active
- ☐ Positive Mental Attitude
- ☐ Resistant to Infection

Unbalanced Nervous System

UNDER-AROUSED
- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking Motivation
- ☐ Poor Concentration
- ☐ Spaciness
- ☐ Constipation
- ☐ Low Pain Threshold
- ☐ Difficulty Waking
- ☐ Irritable
- ☐ Low Energy

UNSTABLE
- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Sleepwalking
- ☐ Hot Flashes
- ☐ PMS
- ☐ Food Sensitivities
- ☐ Bed Wetting
- ☐ Eating Disorders
- ☐ Bipolar Disorders
- ☐ Mood Swings
- ☐ Panic Attacks

OVER-AROUSED
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Tight Muscles
- ☐ Teeth Grinding
- ☐ Anxiety
- ☐ Heart Palpitations
- ☐ Restless Sleep
- ☐ Poor Expression of Emotions
- ☐ Poor Immune System
- ☐ Racing Mind
- ☐ High Blood Pressure
- ☐ Accelerated Aging
- ☐ Irritable Bowel Syndrome

Exhausted Nervous System

- ☐ **Cancer**
- ☐ **Depression**
- ☐ **Dementia**
- ☐ **Lupus**
- ☐ **ALS**
- ☐ **Diabetes**
- ☐ **Stroke**
- ☐ **Multiple Sclerosis**
- ☐ **Hypo/hyperthyroid**
- ☐ **Alzheimers/Parkinsons**
- ☐ **Fibromyalgia**
- ☐ **Chronic Fatigue Syndrome**
- ☐ **Crohn's/Diverticulitis**
- ☐ **Any Form of Arthritis**

According to the CDC & Stanford University, up to 95% of the doctor visits in the USA are triggered by a STRESS-related illness.