



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	_____ Bloating Gas	_____ Bed Wetting	_____ Irregular Heartbeat
_____ Panic Attacks	_____ Belching Gas	_____ Blood in Urine	_____ High Blood Pressure
_____ Allergies	_____ Colon Trouble	_____ Frequent Urination	_____ Low Blood Pressure
_____ Dizziness/Vertigo	_____ Constipation	_____ Incontinence	_____ Pain Over Heart
_____ Fainting	_____ Diarrhea	_____ Declined Libido	_____ Rapid Heartbeat
_____ Fatigue	_____ Difficult Digestion	_____ Impotence	_____ Slow Heartbeat
_____ Headache	_____ Heartburn/Acid Reflux	_____ Sexual Dysfunction	_____ Swelling of Ankles
_____ Migraines	_____ Excessive Hunger	_____ Kidney Infection	_____ Chest Pain
_____ Loss of Sleep	_____ Gall Bladder Trouble	_____ Kidney Stones	_____ Chronic Cough
_____ Weight Gain	_____ Hemorrhoids	_____ Painful Urination	_____ Difficulty Breathing
_____ Loss of Weight	_____ Liver Trouble	_____ Bladder Infection	_____ Shortness of Breath
_____ Nervousness	_____ Nausea	_____ Prostate Problems	_____ Wheezing
_____ Depression	_____ Pain over Stomach	_____ Visual Disturbances	_____ Asthma
_____ Numbness, Tingling	_____ Poor Appetite	_____ Pregnant: Y N	_____ Sinus Infection
_____ Tremors	_____ Vomiting	_____ Date of last period	_____ Congestion
_____ Arthritis-Osteo	_____ Vomiting of Blood	_____ Excessive Menstrual Flow	
_____ Rheumatoid Arthritis	_____ Hearing Loss	_____ Hot Flashes	
_____ Osteoporosis	_____ Ear Noises	_____ Irregular Cycle	
_____ Foot Trouble	_____ Thyroid Dysfunction	_____ Menopausal Symptoms	
_____ Low Back Pain	_____ Ear Infection	_____ Painful Menstruation	
_____ Neck Pain or Stiffness	_____ Ear Ache	_____ Vaginal Discharge	
_____ Pain between Shoulders	_____ Boils		
_____ Spinal Curvature	_____ Bruise Easily		
_____ Swollen Joints	_____ Dryness		
_____ Seizures	_____ Hives		
_____ Muscle Spasm-Cramps	_____ Itchy		
_____ AM	_____ Skin Eruptions (rash)		
_____ PM	_____ Varicose Veins		

Pain, Numbness & Tingling in:

_____ Shoulders
_____ Arms
_____ Elbows
_____ Hands
_____ Hips
_____ Legs
_____ Knees
_____ Feet

_____ Pregnant: Y N
_____ Date of last period
COVID Vaccine: Y N
How many Boosters?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:

☐ Smoking	☐ Eczema	☐ Heart Disease	☐ Miscarriage
☐ Alcoholism	☐ Emphysema	☐ Heart Attack	☐ Multiple Sclerosis
☐ 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](https://www.newlifechiropractors.com), and/or on the office's webpage, www.newlifechiropractors.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
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This consent was signed by: _____(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____



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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.

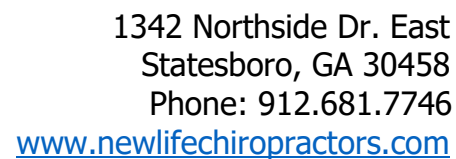
What is Neuro feedback?

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.

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 (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: 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? (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):	

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:



- ☐ High Energy
- ☐ Excellent Health
- ☐ Few Symptoms

- ☐ Mentally Alert
- ☐ Active

- ☐ Positive Mental Attitude
- ☐ Resistant to Infection



UNDER-AROUSSED

- ☐ 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-AROUSSED

- ☐ 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



- ☐ 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.