Your Family Chiropractic LLC
New Patient Questionnaire
Dr. Kayla J. Madler

Patient Information (Please Print)

Please provide a copy of your card & a photo id to the front desk

Name_____ Date _____ Birth Date _______________

Mailing Address_____ City_____ State___ Zip_____

Gender_____ SS#_____ Ethnicity (please check one) ☐Hispanic **or** ☐Non-Hispanic

Race_____ Preferred Language _____ Height _____ Weight _____

Home #(_____)_____ Cell #(_____)_____Work #(_____) _____

E-mail Address_____

Employer _____ Occupation _____ #years _____

Emergency Contact_____ Phone #_____ Relation_____

Whom may we thank for referring you to us? _____ **OR**

How did you find us: Internet?_____ Yellow Page Ad?_____ Other? _____

Name of local primary Physician: _____ May we contact them?_____

Symptoms

Main Complaint_____ How Bad? _____ How Often?_____

When did it start? _____Getting Worse? _____ Getting Better? _____

What activity bothers it the most? _____

When is it at its best?_____ When is it at its worst?_____

Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10

Other Chiropractors?_____ Positive Experience?_____

Other type of physician or therapist?_____ Positive Experience? _____

Secondary Complaint_____

Health History

Tobacco or Alcohol Use-(please check)

Tobacco Use? ☐Yes ☐No ☐Quit

If yes, type, quantity per day, & how long? _____

Alcohol Use? ☐Yes ☐No

If yes, how many drinks per week?_____

Female Only –

How many children?_____ Pregnant?_____ Taking Birth Control Pills?_____

Nursing? _____ Date of last Menstrual Cycle_____ Date of last Mammogram _____

Please check all that apply to you:

☐Actinic Keratosis	☐COPD	☐Migraines	☐Fractures
☐Asthma or Hay Fever	☐Arthritis	☐Parkinson's	☐Osteoporosis
☐Pacemaker	☐Gout	☐ M.S.	☐Herniated Disc
☐Chemical Dependency	☐Chronic Fatigue	☐Epilepsy	☐Fibromyalgia
☐Melanoma	☐Heart Disease	☐Stroke	☐Rheumatoid
☐Kidney Stones	☐Kidney Disease	☐ Hepatitis	☐High Blood Pressure
☐Tuberculosis	☐Diabetes	☐Liver Disease	☐Back Problems
☐Allergies	☐Prostate Problems	☐Emphysema	☐High Cholesterol

☐ Cancer (Type) _____

Numbness on inner thighs? YES NO
Any unexplained weight loss? YES NO
Do you take immunosuppressant's? YES NO
Bladder or bowel problems? YES NO
Pain not improved with rest? YES NO
Number of Corticosteroid shots that you have received? _____

Other Information –

If you are 65+ years old: Have you received the Pneumonia Vaccination? ☐Yes or ☐No
Previous Surgeries and Dates: _____
_____

List ALL Medications you are currently taking: **Please Print** *(If you have a list please give it to the front desk)*

Allergies (Prescription Drugs and Environmental)	Current Medication (Exclude Supplements)

What supplements do you take? _____
_____

What kind of exercise do you do and how much? _____

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office. All outstanding balances are subject to interest and/or late fees.

Patient Signature_____ Date_____

If under 18 years of age, parent or guardian's signature

Chiropractic Informed Consent

To the Patient: Please read this entire document prior to signing. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment I use as a doctor of chiropractic is spinal manipulative therapy. I may use my hands or a mechanical instrument upon your body in such ways as to move your joints. This may cause an audible "pop" or "click", similar as you may experience when you "crack" your knuckles. You may feel a sense of movement.

As part of the analysis, examination, and treatment, you are consenting to the following procedures as needed:

Spinal manipulative therapy, vital signs, range of motion testing, postural analysis, muscle strength, hot/cold pack therapy, palpation, orthopedic testing, neurological testing, traction, electrical muscle stimulation, ultrasound, urinalysis, blood testing, hair analysis, and x-ray.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contra-indications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. The incidences of these complications are very rare.

Other treatment options for your condition may include: Self-administered over the counter analgesics and rest, medical care, hospitalization, surgery, and possibly others. If you choose one of these options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

Notice of privacy practice summary

This summary discloses how health information about you may be used.

Your Family Chiropractic LLC uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you received.

Your Family Chiropractic LLC will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Your Family Chiropractic LLC may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Your Family Chiropractic LLC may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, request a report and retain a copy of your health record, request communication of your information by alternative means at alternative location, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Your Family Chiropractic LLC must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact 307-547-3330.

I have read and understand the above:

Signature _____ Date _____

If under 18 years of age, parent or guardian's signature _____