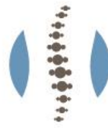

Rushmore Family
CHIROPRACTIC

NEW PATIENT INFORMATION

DATE:_______________

PATIENT INFORMATION

Name: ____ Nickname: ________________________

Reason for Visit:____

____

Gender: M / F Date of Birth: _____/_____/_____ Age: _______ SSN:____-_____-_____

Marital Status: S / M / W / D Home Phone: (____) ____-______ Cell Phone: (____) ____-______

Home Address: ______________________________ City:_________________ State: ___ Zip:________

Email Address: ____

Who may we thank for referring you? ____

Job Title: _______________________ Employer: ________________ Work Phone: (____) ____-_______

Spouse Name: ___________________________________ Spouse Phone Number: (____) _____-_______

Emergency Contact Information

Name: __________________________________ Relation: ____________ Phone: (____) _____-________

Insurance Information

Insurance Company:_________________________________ Name of Primary______________________

Subscriber ID #__________________________________ Group #__________________________________

Patient informed Consent

I, ____, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Rushmore Family Chiropractic. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this content, and by signing below I agree to above-named procedures.

Patient Signature ____

Rushmore Family
CHIROPRACTIC

NAME: ________________________________ DATE: _____/_______/_______

HISTORY OF ILLNESS/ INJURY/ PAIN

LOCATION

Chief complaint and its location: ____

____

TIMING & DURATION

How often do you experience this pain? ____Constant ____Frequent ____Intermittent ____Occasional

What caused the onset? ____

____

Date of the onset? ______/______/_______

SEVERITY

On a scale of 0 to 10 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: ____

____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting
_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

MODIFYING FACTORS

What aggravates the pain/ symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive Movements _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other: ____

What relieves this pain/ symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____ Looking side/side _____Mineral Ice
_____Other: ____

Over the past weeks/ months this complaint is: ______Improving ______Getting worse ______About the same

Have you seen anyone for this condition? ______YES ______NO WHOM? ____________________________________

How did you hear about us? _______________________Have you been to a chiropractor before? If yes, who? ____________________________

Doctor Signature: ____
Patient Signature: ____

Rushmore Family
CHIROPRACTIC

NAME: ______________________________ DATE: _____/_______/_______

SECONDARY COMPLAINT & LOCATION

Location: ____________________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

IF the pain radiates of travels, please identify where to: ____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting

_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

Over the past weeks/ months this complaint is: ______Improving ______Getting worse ______About the same

THIRD COMPLAINT & LOCATION

Location: ____________________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility ____Stiffness _____Spasms _____Cramps

IF the pain radiates of travels, please identify where to: ____

QUALITY

How would you best describe the sensation of the pain/ symptom:

_____Sharp _____Stabbing _____Aching _____Pins & Needles _____Pounding _____Shooting

_____Burning _____Dull _____Tingling/ Numb _____Throbbing _____Crawling _____Stinging

Over the past weeks/ months this complaint is: ______Improving ______Getting worse ______About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

____

____

2. What do you enjoy doing most in your life?

____

____

NOTES / COMMENTS:

____

____

____

Doctor Signature: ____

Patient Signature: ____

Rushmore Family
CHIROPRACTIC

NAME: ______________________________ DATE: _____/_______/_______

Please place a checkmark by the condition that applies to you: P = Present ● N = Not Present ● PP = If it has ever been present in the past

P	N	PP		P	N	PP		P	N	PP		P	N	PP	
			Fatigue				Irritability				Joint Stiffness				Seizures
			Fever				Depression				Spinal Curvature				Dizziness
			Chills				Memory Loss				Back Pain				Tremors
			Night Sweats				Headache				Hot Joints				Loss of Sensation
			Fainting				Muscle Pain				Joint Swelling				Loss of Coordination
			Nervousness				Muscle Weakness				Stiff Neck				Paralysis
			Concentration Loss				Muscle Cramps				Lumps / Masses				

P = Present ● N = Not Present ● PP = If it has ever been present in the past ● Do the same for your family

Family History Key: F = Father● M = Mother● B = Brother● S = Sister● GF = GrandFather● GM = GrandMother **Family History**

P	**N**	**PP**	**Past Problem**	**When and Explanation of Condition** (use back if needed)	**F**	**M**	**B**	**S**	**GF**	**GM**
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/ Chest Pain							
			Diabetes							
			Arthritis							
			Other							

List any allergies: ____

____

Do you have a pacemaker? ____ YES ____NO

Are you Pregnant? ____YES ____NO

Do you think you may be pregnant? ____YES ____NO

FOR DOCTOR'S USE ONLY- PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

Allergic / Immunologic

Constitutional

Endocrine

Gastrointestinal

Genitourinary

Integumentary

Neurological

Respiratory

Cardiovascular

Ears/Nose/ Mouth

Eyes

All Other system reviews negative

Hematological / Lymphatic

Musculoskeletal

Psychiatric

Notes / Comments: ____

____

____

____

____

____

____

Doctor Signature: ____

Patient Signature: ____

Rushmore Family
CHIROPRACTIC

NAME: ______________________________ DATE: _____/_______/_______

PLEASE LIST PAST SURGERIES:

1. ________________________________ Year_________ 2. ________________________________ Year ________

3. ________________________________ Year_________ 4. ________________________________ Year ________

5. ________________________________ Year_________ 6. ________________________________ Year ________

List any other key slips, falls or accidents you've had from childhood to present:	**DATE**	**Have you taken:**	**YES**	**NO**	**YEAR**
1)		Insulin			
2)		Cortisone			
3)		Thyroid Medicine			
4)		Male/ Female Hormones			
5)		Blood Pressure			
What medications are you currently taking? (Include Date)		Tranquilizers/ Sedatives			
1)	4)	Birth Control			
2)	5)				
3)	6)				

Known allergies to medications:
Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: _____ Children's Name(s): ____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well Balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you Smoke? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Do you drink caffeinated beverages? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Do you drink alcoholic beverages? ____NO ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5packs/day

Have you ever used street drugs? ____YES ____NO

Hobbies: ____

____

Patient history was obtained from: ____Patient (Self) ____Father ____Mother ____Son ____Daughter

Notes / Comments: ____

____

____

____

____

____

____

____

Doctor Signature: ____
Patient Signature: ____