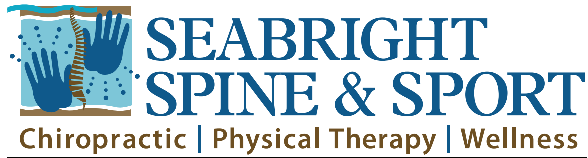


New Patient Information

Date: ____/_____/_______

Welcome! Please allow our staff to photocopy your insurance card (if applicable)

PLEASE PRINT CLEARLY

Full Name:____ Gender: ☐M ☐F Age: ______ Birth Date: ____/____/____

Address: ______________________________________ City:__________________________________ State: _______ Zip: ____________

Home phone: (_____)_________________________

E-mail: ____ Work phone: (_____)________________________

Cell Phone: (_____)________________________

Social Security #: _______-_____-________ Drivers License #:_______________________ Fax: (_____) ________________________

Marital Status: ☐S ☐M ☐D ☐W # of Children: _______ Work Status: ☐Full-time ☐Part-time ☐Retired

Employer: ______________________________________ Occupation:_______________________

Employer Address: ____ City: ___________________ State: _______ Zip: _____________

Females: Last Menstrual Period: _______________ Pregnant? ☐Y ☐N Nursing? ☐Y ☐N

Name of Spouse, Parent or Guardian: ___________________________________ Employer:____

Occupation: ___________________________________ Work Phone: (____)____________

In Case of an Emergency Contact: ____ Relationship: ______________________

Home Phone: (____)________________ Cell Phone: (____)_________________ Work Phone: (____)_______________________

How did you hear about our clinic? Who may we thank for referring you? ____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Seabright Spine and Sport to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office
4. The patient may provide a written request to revoke a consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. We have taken all precautions that are known by Seabright Spine and Sport to assure that your records are not readily available to those who don't need them.
6. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patients Signature: ____ Date: _______________

Spouse's or Guardian's Signature: ____ Date: _______________

SEABRIGHT SPINE & SPORT

Chiropractic | Physical Therapy | Wellness

HEALTH CONCERNS: Please list your top health concerns in order of priority

1) ____
2) ____
3) ____
4) ____

TREATMENT: What type of treatment are you looking for?

□ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

□ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.

□ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____________ Has another doctor(s) treated you for this condition: □Y □N

If yes, whom? ___________________________ Treatment(s): ___________________________________

Have you had any intolerance or reactions to treatments? □Y □N Describe: ________________________________

Is this a recurrence, when was the first time you noticed this problem? _____________________________________

How did it originally occur? ____________________ Has it become worse recently? □Y □ N describe: __________________

How frequent is the condition? □Constant □Daily □Intermittent □Night Only.

How long does it last? □All day □Few hours □Minutes

Is this condition interfering with your : □Work □Sleep □Daily routine □Recreation □Other: ____________________

How long has it been since you really felt good? □Days □Weeks □Months □Years □ > 10 years

Describe the pain: □Sharp □Dull □Numbness □Tingling □Aching □Burning □Stabbing □Other

Is there anything that you can do to relieve the problem? □Y □N If yes, describe: ______________________________

If no, what have you tried to do that has no helped? ____

What do you believe is wrong with you? ____

Are there any other conditions or symptoms that may be related to your major symptom? □Y □N If yes, what?____________

Have you been in an auto accident? □ Past year □ Past 5 years □Over 5 years □Never

Describe: ____

Please check all of the symptoms that apply. (P=Past / C=Current)

P/C

□□Headache
□□Facial pain
□□Eye pain
□□Blurred vision
□□Dizziness
□□Earache
□□Forgetfulness
□□Confusion
□□Sinusitis
□□Teeth Grinding
□□Dry mouth
□□Excessive Thirst
□□Unpleasant Taste
□□Neck Pain
□□Persistent Coughing
□□Unsteady Voice
□□Chest Pressure
□□Slow Heart Rate
□□Rapid Heart Rate
□□High Blood Pressure
□□Other___________________________________

P/C

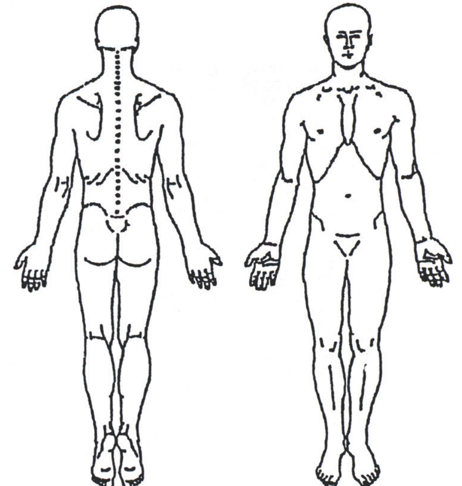
□□Sweating
□□Insomnia
□□Fainting
□□Low Blood Pressure
□□Abdominal Pain
□□Nausea/ vomiting
□□Poor Appetite
□□Fullness of Bladder
□□Urination Difficulty
□□Frequent Urination
□□Constipation
□□Hemorrhoids
□□Decreased Sex Drive
□□Shoulder Pain
□□Swallowing Pain
□□Lump in Throat
□□Sore Throat
□□Convulsions
□□Irritability
□□Impatience

P/C

□□Fatigue
□□Menstrual irregularities
□□Elbow/ Hand Pain
□□Tingling in Hands
□□Clammy Hands
□□Low Back Pain
□□Hip Pain
□□Knee Pain
□□Poor Circulation
□□Swollen Joints
□□Joint Stiffness
□□Swollen Ankles
□□Ankle/foot Pain
□□Tingling in Feet
□□Walking Problems
□□Sore muscles
□□Weak Muscles
□□Paralysis
□□Shaking
□□Feel Loss of Control

Please use the legend symbols below to accurately mark the areas in which you Feel these sensations

Stabbing/Cutting -/// Tingling - T
Burning – XXX Cramping - C
Numbness - ~~ Dull - ###



SEABRIGHT SPINE & SPORT
Chiropractic | Physical Therapy | Wellness

ALLERGIES: Please check and list all allergies.

☐ Food: ____

☐ Medications: ____

☐ Seasonal / Other: ____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	**Date started**
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone replacements (HRT)		
☐ Oral Contraceptives		
☐ Other		

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had.

____

____

____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? ________________

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	☐	☐	☐	☐	________	______

	8+ hrs	7-8hrs	6-7 hrs	5-6hrs	<5rhs
Sleep	☐	☐	☐	☐	☐

	5+	4	3	2
Meals/day	☐	☐	☐	☐

	64+oz	32-64 oz	16-32 oz	<8 oz
Water/day	☐	☐	☐	☐

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly sitting ☐ Mostly standing ☐ Walking / Moving ☐Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___Alcoholism	___Eczema	___Miscarriage(s)	___Tumor(s)
___Anemia	___Emphysema	___Mumps	___Ulcer(s)
___Cancer	___Epilepsy	___Pleurisy	___Other: _________
___Cold sores	___Goiter	___Pneumonia	________________
___Deep Vein Thrombosis	___Gout	___Polio	________________
___Detached retina	___Heart disease	___Rheumatic fever	
___Diabetes	___HIV/AIDS	___Stroke	

____
Patient's Printed Name

____ ____________________
Patients Signature **Date**