New Patient Health History

Legal name_____ Age_____ Date of Birth _____

Gender ☐ Male ☐ Female ☐ Transgender ☐ Nonconforming ☐ Decline to Answer

Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) ☐ Domestic Partnership

Address_____ City_____State_____ Zip_____

Phone_____Work_____e-mail _____

What is your preferred method of contact?_____May we message you if needed? ☐ Yes ☐ No

Occupation_____ Employer_____

Name of Medical Doctor_____ May we contact them if needed? ☐ Yes ☐ No

Have you ever received Chiropractic Care? ☐ Yes ☐ No How did you hear about us?_____

What can we help you with? _____

How long have you had this problem? _____

Is this condition due to an accident? ☐ No ☐ Work ☐ Auto ☐ Home

Is this condition getting worse? ☐ Yes ☐ No ☐ Stable ☐ Unknown

Does anything make the problem worse? _____

Does anything make the problem better? _____

Type of pain: ☐ Aching ☐ Dull ☐ Cramps ☐ Sharp ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Shooting

☐ Burning ☐ Throbbing ☐ Tightness ☐ Swelling ☐ other

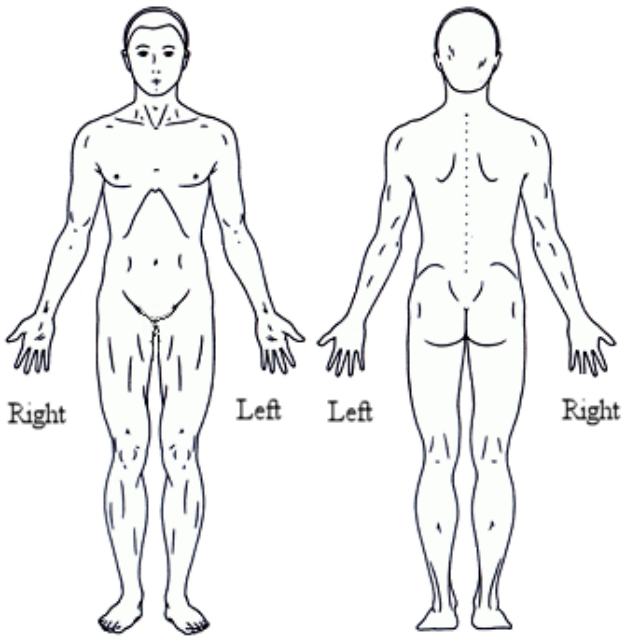
Do the symptoms radiate or travel to any areas of your body? _____

How often do you have this pain? _____

Have you had any previous care or seen any other provider(s) for this problem? _____

What are you doing for it now? _____

Is it working? _____



Mark an X on the pictures where you feel pain, numbness, or tingling.

Please rate the pain
0=No pain - - Worst=10

Headaches _____ / 10
Neck Pain _____ / 10
Shoulder Pain _____ / 10
Elbow/Hand/Wrist _____ / 10
Mid-Back Pain _____ / 10
Low Back Pain _____ / 10
Hip/Knee Pain _____ / 10
Leg Pain _____ / 10

What medications or supplements are you taking? _____

_____

Are you being treated for any other medical conditions? _____

Have you ever had any serious injuries, hospitalizations, surgeries, lengthy illnesses? Yes / No If yes, please describe.

_____

List any allergies you have: _____

Do you use tobacco ☐ No ☐ I quit ☐ smoke ☐ e-cigs/vaping ☐ chew

What is your sleeping habit? ☐ Back ☐ Side ☐ Stomach

Have you had or do you have any of the following?

Cancer	Yes	No
Diabetes	Yes	No
Neurological Disease / Seizures	Yes	No
Stroke	Yes	No
Heart Attack / Heart Disease	Yes	No
Atherosclerosis / Arteriosclerosis	Yes	No
Aneurysm	Yes	No
High Blood Pressure	Yes	No
Depression	Yes	No
Anxiety	Yes	No
Skin Disease	Yes	No
Hypothyroidism	Yes	No
Osteoporosis	Yes	No
Immunodeficiency	Yes	No
Stomach or Bowel Problems	Yes	No
Shortness of breath / COPD	Yes	No
Upper respiratory infection	Yes	No
Asthma	Yes	No
Unintended weight gain / loss	Yes	No

Do you have a family history of ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Diabetes

Please list any persons you would like to authorize as able to receive or discuss medical or financial information regarding your chart/account. (Spouse, child, parent, legal guardian, medical directive, etc.)

_____ _____

Name Relationship

_____ _____

Name Relationship

I have read the above information and certify it to be true and correct to the best of my knowledge.

Signature _____ Date _____

Flynn Chiropractic
2300 Hamilton Blvd. Sioux City, IA 51104
(712) 224-2747

Acknowledgment of Receipt of HIPAA Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Flynn Chiropractic to ensure the privacy of my personal health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Conduct healthcare operations such as quality assessments and accreditation.
- Obtain payment from third-party payers.

ASSIGNMENT AND RELEASE

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I assign directly to Dr. Sean Flynn, all medical benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not they are paid by insurance. I am responsible for copays, coinsurance, deductibles, out-of-pocket charges, and any services deemed patient responsibility by my plan. If I fail to pay, I understand that my outstanding charges may be sent to a collection agency.

_____
Printed Name

_____ _____
Signature of Insured or Legal Guardian **Date**

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Informed Consent To Chiropractic Services

Chiropractic care may include adjustments, soft tissue work, exercise, stretches, elastic taping, electric-stim, or ultrasound. The goal is to reduce pain and improve function. Individual results may vary and I realize a successful treatment outcome cannot be guaranteed.

I understand that with chiropractic treatments, there is a certain risk of but not all inclusive of: soreness or an increase in symptoms after treatment, bruising, muscle or ligament strains or sprains, worsening of disc herniation, bone or rib fractures.

Chiropractic adjustments involve a thrust or distractive force into the joint by hand, an instrument, or moving pieces on the adjusting table. An extremely rare type of stroke has been associated with adjustments of the neck. These people may go to the chiropractor before or during their stroke and that is likely why there is an association. It is important to know that adjustments have not been proven to cause strokes. Research shows that there is no difference in the risk of stroke following a visit to a medical doctor or a chiropractor. Please tell us if you have a family history of stoke or have had a stroke yourself.

I understand and I am informed as to the nature and purpose of the procedures, the risks involved, and the possibility of complications. I do not expect the Doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the Doctor to exercise judgment during care, which the Doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have been read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. This consent will cover the entire course of treatment for my present condition and future condition(s) for which I seek treatment.

_____
Printed Name

_____ _____
Signature of Patient or Legal Guardian **Date**