Confidential New Patient Information

Print Name _____ Date _____

Name you would like to be called _____

Email _____

Street Address_____

City _____ State _____ Zip _____

Cell # _____ Home # _____ Work # _____

Date of Birth _____ Age _____Social Security # _____

Your Occupation _____ Work Duties _____

How did you hear about the office? _____

Marital Status Married _____ Single _____ Divorced _____ Widowed_____

Sex Male_____ Female_____

Number of children _____ Age of children _____

Emergency Contact

Name _____ Relationship _____

Cell # _____ Home # _____

Insurance Information

If you have insurance information please provide the staff with your card.

Insurance Patients I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature _____ Date _____

Patients Without Insurance Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience.
Let us know which one you prefer. (check one) _____ Payment at time of service _____ Payment Plan

Patient's Signature _____ Date _____
(signature of parent or guardian if the patient is a minor)

Name _____ Date _____

Medical History – Section 1

Height _____ Weight_____

Have you ever been to a Chiropractor before? YES_____ NO_____

If YES Doctor's Name: _____

Date of last Chiropractic visit: _____ Reason for Care: _____

Who is your Primary Care Physician _____Phone # _____

List any Conditions you are currently being treated for: _____

FEMALES ONLY: Is there a possibility you are pregnant? YES_____ NO_____

Have you had a DEXA Scan? YES_____ NO_____ If so, when? _____

Have you had a Vitamin D Test? YES_____ NO_____

Smoking _____Current Every Day Smoker _____ Current Some Days Smoker

_____Former Smoker (> than 100 Cigarettes in Lifetime) _____Never Smoked

Please check if you have had or currently have

Fractures _____ Osteopenia _____ Osteoporosis_____

Heart Problems _____ Cancer _____ Blood Disorder/Clotting_____

If you have had the following, or if you suffer from the following, please Check!

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally	Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	___	___	Nervousness	___	___
Migraines	___	___	Vision Changes	___	___
Neck Pain	___	___	Nose Bleeds	___	___
Shoulder Pain	___	___	Ringing in Ears	___	___
Arm/Hand Pain	___	___	Earaches	___	___
Mid Back Pain	___	___	Hearing Loss	___	___
Low Back Pain	___	___	Cough	___	___
Hip Pain	___	___	Chest Pains	___	___
Leg/Foot Pain	___	___	Female Problems	___	___
Disc Problems	___	___	Insomnia	___	___
Arthritis	___	___	Asthma	___	___
Other Joint Pain	___	___	Fatigue	___	___
Numbness	___	___	Frequent Colds	___	___
Joint Swelling	___	___	Diabetes	___	___
Dizziness	___	___	Hypoglycemia	___	___
Nausea	___	___	Digestive Problem	___	___

Name_____Date_____

Medical History – Section 2

Medications YES_____ NO_____ If YES, please list current medication(s) prescription and over-the-counter

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Drug Allergies YES _____ NO _____ If YES, please list below

1. _____ 2. _____

Surgeries YES _____ NO _____ If YES, please list type and date

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Accidents YES _____ NO _____ If YES, please list type and date

1. _____ 3. _____
2. _____ 4. _____

Other Medical History _____

_____

_____

_____

In general would you say your health is? (circle your answer)

1 - Excellent 2- Very Good 3 - Good 4 - Fair 5 – Poor

Compared to one year ago, how would you rate your health in general? (circle your answer)

1 - Much better 2 - Somewhat better 3 - About the same 4 - Somewhat worse 5 - Much worse

BStrong4Life Informed Consent

I hereby request and consent to the performance of an evaluation of my person (or on the patient named below, for whom I am legally responsible), to include some or all of the following tests, procedures or protocols; physical, neurological and orthopedic examination, digital postural analysis, diagnostic x-ray or if by referral, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Dual Energy X-ray Absorptiometry (DEXA or DXA Scan), lab studies including those that may require a blood or urine sample for the purpose of determining my present status and suitability to participation in the physical training and rehabilitation system known as the BStrong4Life™ System. This evaluation and or referral for same, by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic or other licensed medical professionals or their qualified and trained assistants, who now or in the future treat me while employed by, are working or are associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of the BStrong4Life™System Protocols. I understand that this form of training is highly intense, and is designed to impart optimum maximum loading to my neuro-musculoskeletal system in order to produce a positive tissue response which may or may not improve or resolve my present condition. I understand that this form of training is not appropriate for patients who are pregnant or for patients who have fractures; tumors; abdominal aortic aneurysm; markedly advanced osteoporosis, metal implants in the spine, uncontrolled high blood pressure, cardiomegaly, cardiac arrhythmias, history of intracranial hemorrhage, stroke, increased intracranial pressure, clotting or embolism forming disorders, glaucoma or history of detached retina.

I understand and am hereby informed that although BStrong4Life™ Training Protocols are non-invasive and non-surgical, as in other healthcare modalities, there are some risks to this unique form of high intensity training, including but not limited to, muscle soreness or muscle spasms for short periods of time, delayed onset of soreness or muscle cramping up to 3 days following training sessions, aggravating and/or temporary increase in known condition specific symptoms, lack of improvement of symptoms, disc injuries or re-injuries, fractures, and dislocations and joint sprains. I also understand that every possible precaution will be exercised to insure risk of injury is minimized in my case. I do not expect the doctor to be able to anticipate and explain all risks, complications, or responses to this training, I wish to rely on the doctor and all associates to exercise judgment during the course of this training regimen which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that BStrong4Life™ Training is designed to improve overall and core muscular strength, postural stability, and over time improve muscle density (myofibril proliferation) and assist in improving or normalizing bone mineral density (BMD). In addition, this type of training often alleviates certain symptoms directly or indirectly associated with deconditioning of the core musculature, or abnormal postural biomechanics. This conservative approach is entertained with hopes of avoiding other procedures or approaches that inherently posses more risk or potential for complication. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for BStrong4Life™ Training Sessions are final and no refunds will be issued. However, prorated fees for unused, prepaid training will be refunded if you wish to cancel training at any time.

I further understand that there are treatment options available for my condition other than BStrong4Life™ Training. These treatment options include, but are not limited to self-administered, over the counter supplements and exercise; medical care with prescription drugs such as biophosphates or other families of drugs or pharmacological protocols to treat osteopenia or osteoporosis; physical therapy, and in advanced cases of BMD loss, more aggressive medical intervention(s). I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my condition, symptoms, and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to participate in the above-detailed training system. I intend this consent to cover the entire course of training for my present condition and for any future condition(s) for which I seek advice, rehabilitation or treatment.

Name of Patient_____

Signature of Patient/Legal Guardian_____

Witness_____

Date _____