New Patient Information

Personal Information

Name	Today's Date
Street Address	Date of Birth
City | State | Zip	Gender
Email	Phone
Occupation	Marital Status
Family member name(s) and age(s)	
How did you hear about Sota Chiropractic?	

Current Health Concern(s)

Health Concern *in order of importance*	Present Severity 1-10	How long have you had this?	Did this start with an injury? Y/N	Is this constant or does it come and go?
1.				
2.				
3.				

❑ *I do not have any current health conditions and seek wellness / maintenance / preventative care.*

Information regarding your primary health concern:

What makes the condition better? What makes this condition worse?

Are you seeing any other providers for this condition? Y / N If yes, who?

How does this condition affect your daily life?

- ❑ Carrying groceries
- ❑ Sitting to standing
- ❑ Climbing stairs
- ❑ Caring for pets
- ❑ Computer use
- ❑ Lift/play with children
- ❑ Read or concentrate
- ❑ Shower
- ❑ Shave
- ❑ Extended sitting
- ❑ Static standing
- ❑ Walking
- ❑ Sweep/vacuum
- ❑ Dishes
- ❑ Laundry
- ❑ Yard work
- ❑ Garbage
- ❑ Dress
- ❑ Drive
- ❑ Sleep

Have you been to a chiropractor before? Y / N If yes, who & when? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment to restoring your health: _____

Did/Do you have any of the following?

Stroke Cancer Heart Disease Spinal Surgery Seizures Spinal Bone Fracture

Other Health Concerns/Conditions

- ❑ Acid Reflux
- ❑ ADD/ADHD
- ❑ Anxiety
- ❑ Arm Pain
- ❑ Asthma
- ❑ Autism
- ❑ Chest Pain
- ❑ Chronic Fatigue
- ❑ Chronic Sinus
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Headaches
- ❑ High Blood Pressure
- ❑ Hip Pain
- ❑ Incontinence
- ❑ Infertility
- ❑ Irritable Bowel
- ❑ Kidney Problem
- ❑ Knee Pain
- ❑ Leg Pain
- ❑ Liver Disease
- ❑ Low Back Pain
- ❑ Lupus
- ❑ Menstrual Disorder
- ❑ Migraines
- ❑ Mid Back Pain
- ❑ Nausea
- ❑ Neck Pain
- ❑ Nervousness
- ❑ Numbness in hands
- ❑ Numbness in arms
- ❑ Numbness in legs
- ❑ Numbness in feet
- ❑ Sciatica
- ❑ Shoulder Pain
- ❑ Stomach Disorder
- ❑ Thyroid Problems
- ❑ TMJ
- ❑ Ulcers
- ❑ Vertigo
- ❑ _____

History of Physical, Chemical + Emotional Stress

Have you had any significant falls, surgeries, or other injuries? Y / N
If yes, please describe:

Have you been in any auto accidents? Y / N
If yes, please describe:

Please list any medications or supplements you are currently taking:

Do you consume any of the following on a consistent basis? Please circle:

Cigarettes Alcohol Processed Foods Sugar Gluten Dairy

How would you rate your level of physical activity on a weekly basis?

1 2 3 4 5 6 7 8 9 10
sedentary moderately active highly active

How would you rate your quality of sleep?

1 2 3 4 5 6 7 8 9 10
low moderate high

How would you rate your current level of emotional stress?

1 2 3 4 5 6 7 8 9 10
low moderate high

Patient Name: _____ **Date:** _____

Terms of Acceptance

Sota Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our objective is to correct subluxations. Our method to do so is by using specific adjustments.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of the x-rays in our files.
Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate medical pathology. The doctor(s) of Sota Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

FEMALE PATIENTS: To the best of my knowledge, I believe I am not pregnant at the time x-rays are taken. _____ (initial)

FEMALE PATIENTS: I am pregnant at this time and understand x-rays will not be taken today. _____ (initial)

Signature _____

Assignment of Benefits

I assign the rights and benefits of all applicable third party payments to Sota Chiropractic for the service and supplies rendered during the course of my treatment. I agree to pay any deductible or copayment not covered by my insurance company, and further authorize the release of medical information as necessary to process my claims. I understand that any claims denied by the insurance company become my financial responsibility.

This assignment of benefits form includes all rights to collect benefits from the insurance company for services I have received. Additionally, I authorize Sota Chiropractic all rights to proceed against the insurance company obligated to provide benefits in any action in which the insurance company fails to make payment that is due. This includes filing complaints directly to the insurance commissioners in the state I receive treatment and the state where the insurance company is physically located. Should Sota Chiropractic receive any checks made payable to said provider and myself, I authorize endorsing and depositing the check as is standard business practice of my provider.

Signature _____

Patient Name: _____ **Date: _____**