



Wellness and Sport Rehab Center
Dr. Steven Muscari

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Jupiter, FL 33458
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www.NewPathHealth.com

Welcome

General Information

Patient Name: Preferred Name:
Birthdate: Age: Male Female
Mailing Address: City State Zip
Daytime Phone: Evening Phone: Email:
Status: Minor Married Separated Widowed Children Yes No How many
Spouse's Name Referred By:

Employment Information

Employer: Occupation: How Long?:
Address: City: State: Zip:

Insurance Information

Company Name: Phone#:
Address: City: State: Zip:
Insured Id# Group#:
Insured Name: Relation:
Date of Birth Insured Employer:

Reason For Visit

The reason for this visit is a result of: Sports Work Auto Trauma Chronic
Explain what happened:
Please describe the pain and it's location:
When did condition begin? Is it getting worse? Yes No Constant Comes and Goes
Does it interfere with your Sport Work Sleep Daily Routine
Have you had this or similar condition in the past?: Yes No Explain
Have you been treated by a medical physician for this condition Yes No
If so, whom and where?:
Have you been treated by a chiropractor before? Yes No
If so, whom?:

Health History

Please select all choices that apply:

- Abdominal Pain Cancer Spinal Disc Disorder Arthritis
Bulimia Kidney Disease Anorexia High BP
Fainting Polio Convulsion Lung Disease
Irritable Colon Sinus Trouble Heart Disease Asthma
PMS Angina Liver Disease Dizziness
Sickle Cell Anemia Headaches Prostate Disease HIV/AIDS
Allergies Kidney Stones Stroke MS
Scoliosis Ulcer Breast Disorder Osteoporosis



Health History

Patient Exercises Rarely Moderately Regularly Never

Patient Smokes Yes No

Patient uses alcohol: Rarely Moderately Regularly Never

Allergies: _____

Medication

Please list medication currently taking _____

Past Surgical/Hospitalization History

Please list any other serious medical condition you have or ever had: _____

Type of Surgery/Cause of Hospitalization _____

Where: _____ Surgeon: _____

Review of Systems

Height: _____ Weight: _____ lbs

Cardiovascular: chest pain palpitations artificial heart valve hypertension heart murmurs

Respiratory: shortness of breath cough tuberculosis (or exposure to TB)

Musculoskeletal: muscle pain joint pain joint swelling

Neurological: headaches dizziness weakness unsteady walking numbness seizures

Eyes: glasses double vision tearing blindness

ENT: hearing loss ringing in ears nose bleeds trouble swallowing

Dermatologic: rash itching changes in hair changes in nail

GI: nausea vomiting constipation liver disease black tarry stools ulcers

GU: urgency frequency blood in urine stones retention incontinence

Endocrine: intolerance to heat/cold diabetes thyroid problems

General: weight loss weight gain fevers chills poor sleep

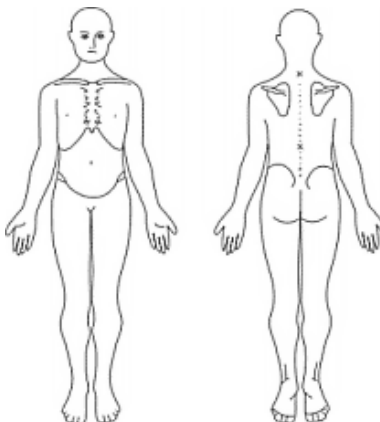
Psychiatric: anxiety depression suicidal thoughts substance abuse

Hematologic: anemia bleeding tendency previous transfusion reaction

Lymphatic: lymph node enlargement lymph node tenderness lymphedema

Immunological: immunocompromised HIV/AIDS

Please indicate where you are experiencing symptoms?



**New Path Chiropractic LLC
DISCLOSURE & CONSENT
CHIROPRACTIC ADJUSTMENTS AND CARE**

***TO THE PATIENT:** You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.*

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand, and I am informed that, there are some risks to chiropractic examination and treatment including, but not limited to: fractures (broken bones), increased symptoms and pain, spinal or disc injuries, no improvement of symptoms or pain, dislocations, stroke and sprains/strains

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition.

To be completed by the patient:

print name

signature of patient

date signed

To be completed by the patient's representative:

print name of patient

print name of patient's representative

signature of patient's representative

as: _____
relationship/authority of patient's representative

date signed

To be completed by doctor or staff:

Doctor's signature

date