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New Path CHIROPRACTIC
wellness and sports rehab

Wellness and Sport Rehab Center
Dr. Steven Muscari

Welcome

General Information

Patient Name:_____Preferred Name:_____
Birthdate:_____ /_____/_____ Age:_____ □ Male □ Female
Mailing Address:_____ City_____ State___ Zip_____
Daytime Phone:_____ Evening Phone:_____ Email:_____
Status: □ Minor □Married □Single 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

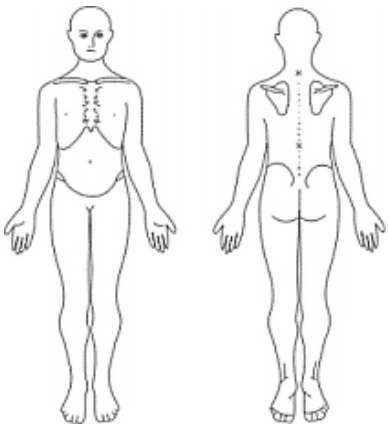
Psychiatric: □anxiety □depression □suicidal thoughts □substance abuse

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