



New Path
CHIROPRACTIC
wellness and sports rehab

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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

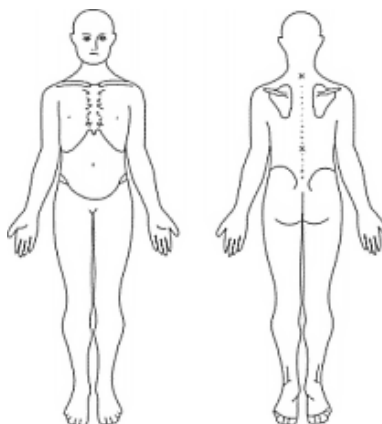
Psychiatric: ☐anxiety ☐depression ☐suicidal thoughts ☐substance abuse

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 parent/guardian

signature of patient's parent/guardian

Relationship to patient

date signed

To be completed by doctor or staff:



Doctor's signature

date

CANCELLATION POLICY/NO SHOW POLICY

We understand that there may be times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for an appointment.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$25 cancellation/no show fee. This will not be covered by your insurance.

Print Patient Name

Signature Patient/Guardian

Date Signed

FOR PATIENTS USING INSURANCE (FL Blue, BCBS, Aetna, Cigna)

While we diligently try to verify what your insurance and plan will cover, and what they state their member's responsibility for payment is, we sometimes get it wrong.

Should there be an overpayment on your part, we will gladly credit your account. Should there be a balance due, we will do what we can to minimize what we need to collect from you.

We are sorry for any inconvenience this may cause, and we thank you in advance for your understanding. You are more than a patient to us.

Most Sincerely,

Dr. Steve and Staff

Print Patient Name

Signature Patient/Guardian

Date Signed