NEW PATIENT INFORMATION

WELCOME to Genesis Chiropractic…your first adjustment towards a healthier lifestyle.

First Name_____ Last Name_____ Age____ Birth Date___/___/___

Address_____ City_____ State___ Zip_____

Today's Date___/___/___ Home #_____ Cell #_____

Work #_____ E-Mail_____

Occupation_____ Employer_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse/Partner_____

# of Children_____ Names/ages of Children_____

Hobbies/Interests_____

Who may we thank for referring you to our office?_____

Have you ever seen a chiropractor before? ☐ Yes ☐ No If yes, who?_____

Please check if you are here for any of the following: ☐ Car Accident ☐ Work Injury

Method of Payment for Today: ☐ Cash ☐ Check ☐ Credit Card

List your chief complaints in order of severity:

1)_____Start Date: _____

2)_____Start Date: _____

3)_____Start Date: _____

Patient Signature_____

By signing this form, I authorize the release of all information to my insurance companies. I authorize my insurance company to remit payment directly to the doctor. I hereby give my permission to receive chiropractic care performed by Dr. Krantz and staff. I understand that regardless of any insurance coverage, I am personally responsible for my bill. I also understand any nutritional program is not intended as primary therapy for any disease. Supplements are provided solely to support good nutrition with the intent of supporting the physiological and biochemical processes of the human body. We do not offer to diagnose, treat, cure, or prevent any disease or condition other than neuromusculoskeletal conditions. We do expect payment at the time of service unless otherwise specified.

genesis CHIROPRACTIC Center, S.C.

TERMS OF ACCEPTANCE: When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. We have found that if each patient understands the meaning and goal of chiropractic care, they respond much better to their care. This is why here at Genesis Chiropractic, patient education is a priority. Please understand that chiropractic has only one goal and it is important that each patient understands both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment and help you reach your goals.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of a subluxation. Our chiropractic method of correction is by specific adjustments of the spine. As with any form of health care, in very rare instances, chiropractic care may pose certain risks. Sprain, strain, or general aggravation of an inflammatory condition may result from certain chiropractic maneuvers. According to research, the chance of this is approximately 1 in 3.3 million. As with many health related procedures, a patient may have soreness during the initial phase of care.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which may cause alteration in the nerve function and interference to the transmission of mental impulses from the brain through the nervous system to the rest of the body. This can result in a lessening of the body's innate ability to express its maximum health potential and a state of dis-ease. We do not offer to diagnose or treat any condition other than vertebral subluxation nor do we offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter an unusual finding, we will advise and refer you to a health care professional that specializes in that area of health care.

OFFICE POLICIES

For best results, visit frequency should be kept according to your suggested treatment plan.
It is best for missed appointments to be made up within 48 hours for you to see best results.
Please call if you are going to be late.
If three or more appointments are missed without any call or notification, we will consider your case self dismissed.
Payment in full is to be expected after each treatment, unless other arrangements have been made.
Any discount for commitment to a plan will be void if care ends prematurely. You will then be sent a bill for any balance owed.

HIPPA PRIVACY INFORMATION

By signing below I agree that I have had the opportunity to read the offices HIPPA privacy regulations and patient's right and have been offered a copy of them for my records.

_____ _____

Patient Signature Date

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.

CHILDREN'S NEW PATIENT FORM

Today's Date___/___/___

Child's First and Last Name_____Age____ Birth Date___/___/___

Parent's/Guardian's Name_____Relation to Child_____

Home # _____ Cell # _____

Chief Complaint

What is the main reason for bringing your child into the office?_____
_____

When did this issue begin?_____How often does the issue occur? ☐ Constantly ☐ Comes and goes

How much does the complaint affect daily activities/routines? ☐ Not at all ☐ Somewhat ☐ Often ☐ All the time

History

Does your child have any food allergies? ☐ Yes ☐ No If yes, list:_____

Has your child been immunized according to the recommended schedule? ☐ Yes ☐ No

If so, did they have any negative reactions to vaccinations? ☐ Yes ☐ No If yes, were they reported? ☐ Yes ☐ No

Has your child ever had any surgeries? ☐ Yes ☐ No If yes, explain_____

Has your child ever been on antibiotics? ☐ Yes ☐ No If yes, how many rounds?___Reason:_____

Is your child currently taking any medications? ☐ Yes ☐ No If yes, what type?_____

Is your child currently taking any vitamins? ☐ Yes ☐ No If yes, what type?_____

Have any of the following occurred?

☐ Fall from a tree	☐ Car accident	☐ Allergies/Asthma	☐ Leg/Knee pain
☐ Fall off a bicycle	☐ Sports accident	☐ Hyperactivity/Autism	☐ Bed wetting
☐ Fall off of playground unit	☐ Scoliosis	☐ Learning difficulties	☐ Stomach pains
☐ Other:_____	Explain:_____		

Please check any sports that your child plays:

☐ Soccer	☐ Football	☐ Gymnastics	☐ Karate	☐ Hockey
☐ Lacrosse	☐ Basketball	☐ Dance	☐ Wrestling	☐ Baseball/Softball
☐ Volleyball	☐ Swimming	☐ Tennis	☐ Rugby	☐ Other_____

Please check all health issues your child has experienced in the last **6 months**, even if they do not seem to relate to any current problem(s):

___Allergies	___Headache/Migraine	___Loss of Smell	___Ringing in Ears
___Asthma	___Heartburn	___Loss of Taste	___Shortness of Breath
___Cancer	___High Blood Pressure	___Low Back Pain	___Shoulder Pain
___Constipation	___Hip Pain	___Menstrual Pain	___Sinus Congestion
___Depression	___Indigestion/Gas	___Mood Swings	___Sleeping Problems
___Diabetes	___Irregular Cycle	___Neck Pain/Stiffness	___Sore Throat
___Diarrhea	___Irritability	___Nervousness	___Stomach Pain
___Dizziness	___Knee Pain	___Numbness in Fingers	___Swollen Joints
___Fainting	___Light Bothers Eyes	___Pins/Needles in Arms/Hands	___Tension/Anxiety
___Fatigue	___Loss of Balance	___Pins/Needles in Legs/Feet	___Upper Back Pain
___Frequent Urination	___Loss of Memory	___Poor Concentration	___Ulcers

Please check any conditions that your child's **family members** have had in the past or currently have (including siblings, parents, and grandparents):

___AIDS	___Diabetes	___ Malaria	___ Polio
___Alcoholism	___Emphysema	___ Measles	___ Rheumatic Fever
___Anemia	___Epilepsy/Seizures	___ Multiple Sclerosis	___ Scarlet Fever
___Appendicitis	___Gout	___ Mumps	___ Stroke
___Arteriosclerosis	___Heart Disease	___ Osteoporosis	___ Tuberculosis
___Cancer	___Hyper/Hypothyroidism	___ Pneumonia	___ Typhoid Fever

How would you rate your child's diet? ☐ Well balanced ☐ Average ☐ High amounts of sugar and processed foods
How much water does your child drink per day? _____

Does your child drink milk? ☐ Yes ☐ No If yes, how much per day? _____
Number of hours your child sleeps: ___/night

Has your child been diagnosed with any other diseases/disorders? ☐ Yes ☐ No If yes, list:_____
_____

Is there anything else we should know about your child?_____
_____
_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this clinic and its doctors to administer care as they deem necessary to my child. I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are preformed. X-Rays remain the property of this clinic, yet are transferrable to other providers as needed.

Signed_____ Date_____