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.

INFANT 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

Prenatal History

Is your child adopted? ☐ Yes ☐ No

Did you take any medications during your pregnancy? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No

Did you consume alcohol during pregnancy? ☐ Yes ☐ No

Did you have any complications during your pregnancy? ☐ Yes ☐ No If yes, explain_____

Did you have an ultrasound during this pregnancy? ☐ Yes ☐ No If yes, how often?_____

Birth History

Birthing place: ☐ Home ☐ Birthing Center ☐ Hospital Type of birth: ☐ Vaginal ☐ C-Section

Provider: ☐ Midwife/Doula ☐ OB-GYN ☐ Other_____ Was your labor induced? ☐ Yes ☐ No

What position did you deliver in? ☐ Squatting ☐ On Back Were any medications used? ☐ Yes ☐ No

☐ Other_____ What type?_____

Birth trauma: ☐ Doctor Assisted ☐ Twisting and/or pulling ☐ Vacuum Extraction ☐ Forceps

Newborn trauma (If any, please explain):_____

APGAR Score: At Birth ___/10 After 5 minutes ___/10 ☐ Unsure

Did your child have a misshaped skull/head? ☐ Yes ☐ No

Did your child have purple markings on their face/head? ☐ Yes ☐ No

Do you/did you breastfeed your child? ☐ Yes ☐ No If yes, for how long?_____

Does your child prefer one breast/side over the other? ☐ Yes ☐ No If yes, ☐ Right ☐ Left

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

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

Reason for vaccination: ☐ Informed Decision ☐ Didn't know I had a choice ☐ Recommended

Did your child 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:_____
Number of rounds of *other* prescription medications your child has taken:_____ 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 changing table	☐ Tonsillitis	☐ Frequent ear infections	☐ Reaction to vaccines
☐ Repeated infections/colds	☐ Constipation	☐ Frequent Fevers	☐ Fall down stairs
☐ Fall off of playground unit	☐ Sleeping problems	☐ Involvement in car accident	☐ Colic
☐ Play in a Johnny Jumper	☐ Fall out of crib	☐ Inadequate weight gain	☐ Frequent diarrhea

☐ Other:_____ Explain:_____

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:___/day (nap) and ___/night

Has your child been diagnosed with any 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_____