New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Email _____

Your email will NOT be shared with any 3d parties, and is used for general office announcements and promotions.

Mailing address

Address _____ City _____ State _____ Zip _____

Telephone (work) _____ (home) _____ Referred By _____

Age _____ Birth date _____ Social Security # _____ Number of children _____

Occupation _____ Employer _____

Marital Status _____ Spouse's name _____ Spouse's Occupation _____

Spouse's employer _____ Spouse's health status _____

Emergency contact _____ Phone _____

Current Complaints

Nature of injury: Automobile* ☐ Work ☐ Other ☐

Please describe _____

_____

Date of injury _____ Date symptoms appeared _____

Have you ever had same condition? ☐ No ☐ Yes If yes, when? _____

List other practioners seen for this injury/condition _____

Have you ever been under chiropractic care? ☐ No ☐ Yes

If yes, please describe _____

Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had surgery?	☐	☐	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

_____

_____

_____

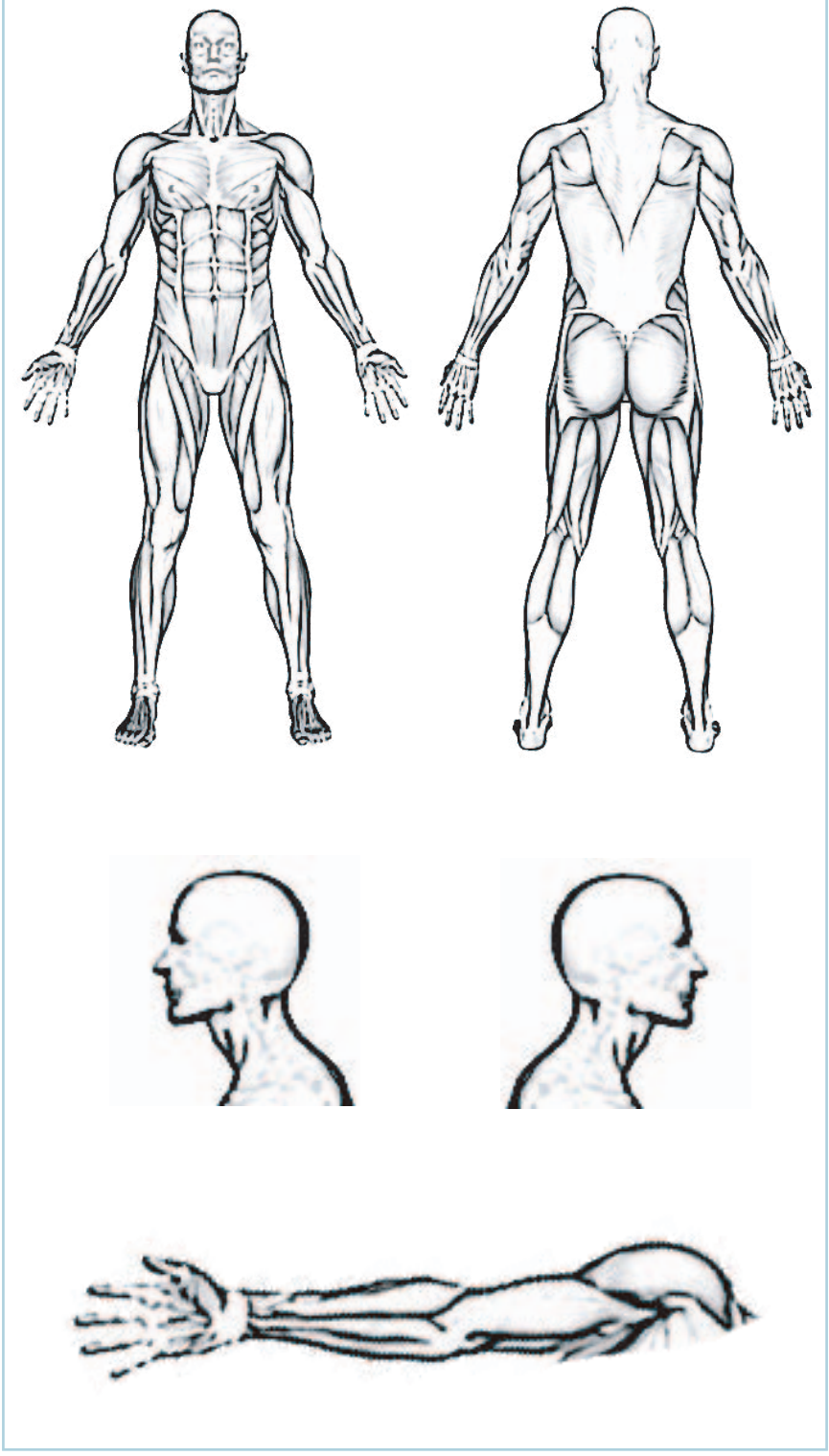
Have you ever suffered from:

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma ☐
- Back Pain ☐
- Breast lump ☐
- Bronchitis ☐
- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heart Beat ☐
- Irregular Cycle ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of memory ☐
- Loss of balance ☐
- Loss of smell ☐
- Loss of taste ☐
- Lumps In Breast ☐
- Neck Pain or Stiffness ☐
- Nervousness ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of breath ☐
- Sinus Infection ☐
- Sleep problems/insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other: ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing



FINANCIAL POLICY

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. This practice accepts cash, personal check, and credit cards as the primary method of payment.

There is a $30.00 service charge for returned checks.

If you are a visitor of the lake area or are a part-time resident, payment is always due at the time of service with cash or credit card.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you.

Cancellations are requested 24 hours prior to the appointment.

I have read and understand the Practice Financial Policy. I agree to assign insurance benefits to Larry Mark Goforth, D.C. whenever necessary. I also understand that any x-rays taken and any medical records concerning my care at this clinic remain property of Larry Mark Goforth, D.C. and remain in the clinic.

Signature of insured/Authorized representative: _____Date: _____

INFORMED CONSENT

I understand that this office, its doctors & staff are accepting my case based on examination findings & believe that outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of chiropractic, acupuncture, Laser Therapy and physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor whom I am legally responsible by a health care provider of the facility.

Signature of insured/Authorized representative: _____Date: _____

Goforth Health Center, LLC.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.**
- **The Practice reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease.**
- **The Practice may condition receipt of treatment upon the execution of this Consent.**

The Consent was signed by: _____

Printed Name of Patient or Representative: _____

Signature Date: _____

Relationship to Patient (if other than patient): _____

Witness: _____

Printed Name: _____Practice Representative

Signature Date: _____