Barneveld Family Chiropractic

New Patient Information Form

Date:_____

Last Name:_____

First Name:_____ Mid Init:_____

Address:_____City:_____St:_____Zip:_____

Home Ph:_____Cell Ph:_____Birth Date:_____

Marital: M S D W Social Security Number:_____

Email Address:_____

Occupation & Employer:_____

Work Phone:_____

If you have insurance coverage please provide your insurance card. If you do <u>not</u> have insurance, payment is due at the time of the service, refer to Consent for Use form for details.

<u>Emergency Contact:</u>

Name: _____ Relationship:_____

Phone #: _____ Work Phone #:_____

Please check all of the reasons you selected us for your care: Which is the primary reason? #____

1. Previous BFC Patient__
2. Location__
3. Insurance Handbook__
4. Google/Internet__
5. Newspaper__
6. Mailing__
7. BFC Website__
8. Reputation of Clinic__
9. Referred by family/friend(name)_____
10. Phone Book/ Yellow Pages____
11. Radio/ Media____
12. Other _____

I acknowledge receipt of a copy of the Consent for Use or Disclosure of Health Information/Notice of Privacy Practices, Marketing Authority, Billing Authorization & Release, and Informed Consent to Treat, and I understand and agree to its terms. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

We encourage your feedback and we will not retaliate against you in any way for the filling of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, any information we create or receive in the future. We will distribute any revised

_____

Print Patient Name

_____ _____

Signature of Patient or Personal Representative **Effective Date**

Consent for Treatment of Minor (If applicable)

I, being the parent, guardian or custodian of _____, a minor, the age of ____, do hereby authorize, request and direct Dr.'s Kimberly Horsfall and/or Casey Schultz to perform, in her/his judgement, and necessary examination, X-ray, and chiropractic treatment for the condition.

_____

Print Parent or Guardian name

I acknowledge receipt of a copy of Notice of Privacy Practices, and my understanding and my agreement to its terms.

Barneveld Family Chiropractic, LLC
101 S. Jones Street
Barneveld, WI 53507
ph 608.924.2424 fax 608.924.2424

Barneveld Family Chiropractic
HEALTH HISTORY FORM

Name: _____Date: _____

Family Physician: _____ Clinic:_____

Clinic Phone #:(_____)_____ Date of last physical exam:_____

Sex: M F Height:_____ Weight:_____ Age:_____ # of Children: _____

✔ **Check the following conditions you have or have had. - ⭕ Circle items that are common to family members.**

GENERAL
- ☐ Alcoholism
- ☐ Allergy
- ☐ Anemia
- Eczema
- ☐ Appendicitis
- eruptions/ rash ☐ Cancer
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dizziness or Fainting
- ☐ Headache
- ☐ Multiple Sclerosis
- ☐ Nerve Problems
- ☐ Numbness
- ☐ Polio
- irregularities
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tuberculosis

MUSCLE & JOINT
- ☐ Arthritis
- ☐ Foot trouble
- ☐ Gout
- ☐ Low back pain
- ☐ Neck pain or stiffness
- ☐ Pain between shoulders
- ☐ Sciatica
- ☐ Swollen joints

pain/numbness
- ☐ shoulders ☐ hips
- ☐ arms ☐ legs
- ☐ elbow ☐ knees

GASTRO-INTESTIONAL
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Distension of abdomen
- ☐ Gall bladder trouble
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Pain over stomach
- ☐Ulcers

EYES, EARS, NOSE & THROAT
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Ear discharge
- ☐ Ear noises/ ringing
- ☐ Eye conditions/infections
- ☐ Goiter
- ☐ Nasal obstruction
- ☐ Nosebleeds
- ☐ Sinus infections

HABITS: (Patient Only)
- ☐ Alcohol
- ☐ Coffee
- ☐ Drugs
- ☐ Medications
- ☐ Tobacco

CARDIO-VASCULAR
- ☐ Chest pain
- ☐ Hardening of the arteries
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heartbeat
- ☐ Swelling of the ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Emphysema
- ☐ Spitting up blood
- ☐ Spitting up phlegm

HAVE YOU EVER: (Patient Only)
- ☐ Had previous Chiropractic care
- ☐ Been knocked unconscious
- ☐ Used a crutch or other support
- ☐ Been treated for a spine or nerve disorder
- ☐ Had a fractured bone
- ☐ Been hospitalized for an event other than surgery
- ☐ Ever has a surgery (please list):_____
- _____
- _____
- _____

SKIN
- ☐ Bruises
- ☐ Dryness
- ☐ Skin

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Hot Flashes
- ☐ Inability to control bladder
- ☐ Kidney infections or stones
- ☐ Menstrual
- ☐ Menstrual pain
- ☐ Miscarriage
- ☐ Painful urination

☐ hands ☐ feet ☐Vitamins