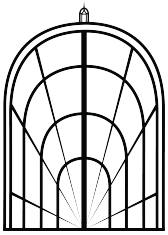

ARCADE
CHIROPRACTIC

Dr. Andy Ingram
401 Euclid Ave. STE 140
Cleveland, OH 44114
(216) 522-0300
www.arcadechiro.com

CHIROPRACTIC NEW PATIENT INFORMATION

Patient Name_____ Date_____

Address_____

City_____State_____ Zip_____

Birthdate_____ Age_____ Sex ☐ Female ☐ Male

Phone Number(s)_____

Email_____

Marital Status: ☐ Single ☐ Married ☐ Minor ☐ Widowed
☐ Divorced ☐ Separated ☐ Partnered for ____years

Spouse/Partner's Name_____

Spouse/Partner's Employer_____

Occupation_____

Employer/School's Name_____

Employer/School's Phone_____

Emergency Contact

Emergency Contact's Name_____

Relationship to Patient_____

Phone Number_____

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No Date of Accident_____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other_____

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other_____

Attorney's Name_____

How did you hear about us?

☐ Google ☐ Social Media ☐ Reference_____ ☐ Other_____

Patient Condition

Reason for visit_____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

Rate the severity of your pain on a scale of 1 (least) to 10 (most severe) _____

Type(s) of pain: ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ swelling ☐ shooting ☐ burning ☐ tingling ☐ cramps ☐ stiffness ☐ other_____

How often do you have this pain? _____ Is it: ☐ constant ☐ intermittent

Does it interfere with your: ☐ work ☐ sleep ☐ daily routine ☐ recreation

Which activities are painful to perform?

☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down ☐ other_____

What treatment(s) have you already received for your condition? ☐ medication ☐ surgery ☐ physical therapy ☐ chiropractic services ☐ none ☐ other _____

Name and phone of previous doctor(s)_____

Health History

Medications	Supplements	Known Allergies

Date of last:

Physical Exam _____ Spinal Exam_____

Chest X-ray_____ Spinal X-ray _____

Dental X-ray _____ Blood Test _____

Urine Test _____ MRI _____

CT Scan _____ Bone Scan _____

Are you pregnant? ☐ yes (Due Date_____) ☐ no ☐ breastfeeding

Health History

Place a check to indicate if you have had any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Rheumatic Fever
☐ Allergy Shots	☐ Epilepsy	☐ Migraine Headaches	☐ Scarlet Fever
☐ Anemia	☐ Fractures	☐ Miscarriage	☐ Sexually Transmitted
☐ Anorexia	☐ Glaucoma	☐ Mononucleosis	Disease
☐ Appendicitis	☐ Goiter	☐ Multiple Sclerosis	☐ Stroke
☐ Arthritis	☐ Gonorrhea	☐ Mumps	☐ Suicide Attempt
☐ Asthma	☐ Gout	☐ Osteoporosis	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Heart Disease	☐ Pacemaker	☐ Tonsillitis
☐ Breast Lump	☐ Hepatitis	☐ Parkinson's Disease	☐ Tuberculosis
☐ Bronchitis	☐ Hernia	☐ Pinched Nerve	☐ Tumors/Growths
☐ Bulimia	☐ Herniated Disk	☐ Pneumonia	☐ Typhoid Fever
☐ Cancer	☐ Herpes	☐ Polio	☐ Ulcers
☐ Cataracts	☐ High Blood Pressure	☐ Prostate Problem	☐ Vaginal Infections
☐ Chemical Dependency	☐ High Cholesterol	☐ Prosthesis	☐ Whooping Cough
☐ Chicken Pox	☐ Kidney Disease	☐ Psychiatric Care	☐ Other(s) _____
			_____

Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Habits

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Smoking: ☐ Yes ☐ No ☐ Tobacco ☐ Vaping ☐ Marijuana Amount per day____

Alcohol: ☐ Yes ☐ No Number of alcoholic drinks per week _____

Coffee/Caffeine Drinks: ☐ Yes ☐ No Number of caffeinated drinks per week _____

High Stress Level: ☐ Yes ☐ No Reason_____

Pharmacy

Pharmacy Name_____ Pharmacy Phone_____

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HIPAA RELEASE

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 and required by April 14, 2003, Arcade Chiropractic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use of and/or disclosure of protected health information described below.

I hereby consent to this practice to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice. This consent includes contact of and discussion with other healthcare professionals for my care and treatment.

I hereby authorize the use and/or disclosure(s) of the following protected health information that pertains to me: my medical records and diagnoses, including but not limited to all lab/x-ray reports, progress reports, and other information.

I understand that I have the right to:

- Refuse to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.
- To inspect and obtain a copy of any protected health information disclosed relating to this authorization.
- Receive a signed copy of this authorization.

Signature:_____

Printed Name: _____

Relationship if not patient:_____

Date: _____

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CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Andy Ingram to perform diagnostic tests and render chiropractic adjustments, NAET treatments, and/or other treatment to my child _____.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

IF APPLICABLE: Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature:_____

Printed Name: _____

Relationship to Patient:_____

Date: _____