New Patient Information

Chiropractic Clinic of Three Forks, PO Box 1307, Three Forks MT 59752, 406-285-6935

Please complete all questions

Name_____ Date_____

Address_____City_____State___Zip_____

Home Phone_____ Cell_____Email_____

Birth Date_____Age_____Gender _____ Marital Status_____

Employer_____Occupation_____

Spouse's Name_____Spouse's Employer_____

Children's Names & Ages_____

Your Favorite Hobbies_____

Who may we thank for referring you?_____

When did you last see a chiropractor?_____Who?_____

List other doctors you have seen recently_____

Medications_____

Surgeries_____

Who is financially responsible for this bill?_____

Emergency Contact Name_____Phone Number_____

What are your major complaints?_____

On a scale from 1-10 how important is your health to you?_____

How many auto accidents have you been in?_____Motorcycle Accidents?_____

Which of the following sports have you been involved in? (circle)
Football Basketball Baseball Soccer Hockey Gymnastics Martial Arts
Dance Wrestling Horseback Riding Skating Water Skiing Other_____

Have you ever: [ ] Fallen down stairs [ ] Had a stress or strain injury while working
[ ] Slipped on ice or snow [ ] Had a sports injury

Do you: [ ] Sit more than four hours a day [ ] Drive more than one hour a day
[ ] Work at a computer more than two hours a day [ ] Use Tobacco

Please check all the health complaints you are experiencing:

[ ] Neck Pain	[ ] Arm/Hand Problems	[ ] Ear Infections
[ ] Upper/Mid Back Pain	[ ] Leg/Foot Problems	[ ] Frequent Colds
[ ] Low Back Pain	[ ] Asthma	[ ] Digestive Problems
[ ] Headaches	[ ] Allergies_____	[ ] High Blood Pressure
[ ] Spinal Curvature	[ ] Sinus Problems	[ ] Diabetes

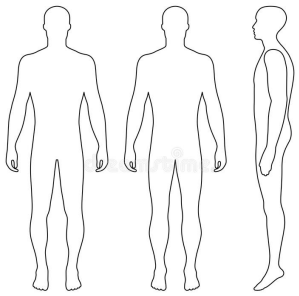
How long have you had the above complaint(s)?_____

How often have you had the above complaint(s)?_____

Is your problem(s) worse in the [ ] morning [ ] mid day
[ ] night [ ] all the time [ ] after activity?

Do you experience any of the following sensations?
[ ] Sharp pain [ ] Dull Pain [ ] Throbbing [ ] Aching [ ] Burning
[ ] Tingling [ ] Numbness [ ] Other_____

*Please mark areas of concern on the picture



Initials____ The doctor will use hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as an "Adjustment". As the joints in your spine or extremity are moved, you may experience a "pop" as part of the process. There are certain complications that can occur as a result of a spinal or extremity adjustment. These complications include, but are not limited to, muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, oculosympathetic palsy, costovertebral strains and separation. A rare complication includes, but is not limited to, stroke. The most common complication or complaint following spinal or extremity adjustments is an ache or stiffness at the site of the adjustment.
The doctor is aware of these complications, and in order to minimize their occurrence, will take precautions. These precautions include, but are not limited to, the doctor taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of X-rays (see below)

Initials____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual cycle _____

Initials____ I instruct the chiropractor to deliver care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials____ I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that the Chiropractic Clinic of Three Forks will provide the necessary information to assist me in making collections from the insurance company and any amount authorized to be paid directly to the Chiropractic Clinic of Three Forks will be credited to my account. I, however, clearly understand and agree that **I am personally responsible for payment due for services rendered.**

Initials____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature_____Date_____

Guardian's Signature authorizing Minor's care_____