New Member Packet

Patient Name: _____

Appointment Scheduled For: _____

Attached you will find the necessary forms to **COMPLETE** and **BRING WITH YOU** on your scheduled appointment date.

In the event that you are not able to keep your appointment time, we require a minimum of a 24-hour notice of schedule changes. Please call our office as soon as possible so that we may give that appointment to someone on our waiting list. At that time we will gladly reschedule your appointment.

Thank you for your cooperation. We look forward to serving you. If you have any further questions please contact our office.

Sincerely,

Dr. Bethany Raudenbush

Contact Information:

900 N Swallowtail Dr. Suite 104D Port Orange, FL 32129

Phone: (386) 872-5313

www.focusforwardchiropractic.com

BETHANY RAUDENBUSH, D.C.

PLEASE PRINT

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Today's Date: _____

Name: _____ **DOB**: _____ **[ ] M [ ] F**

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail: _____

Employer: _____ Referred By: _____

Spouse's Name: _____ Spouse's Office Phone: _____ **# Children**: _____

Nearest Relative: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

HEALTH INFORMATION

Have you received chiropractic care before? [ ] No [ ] Yes Dr. _____

What is your major complaint? _____

_____

Other complaints: _____

_____

How long have you had this condition? _____ Have you had this or similar conditions in the past? [ ] No [ ] Yes If yes, when? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? [ ] Yes [ ] No [ ] Constant [ ] Comes and goes

Is this condition interfering with your: [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other: _____

Other doctors who have treated this condition: _____

_____

List surgical operations and years: _____

_____

Drugs you now take: [ ] Nerve pills [ ] Pain killers [ ] Muscle relaxers [ ]Pep pills

[ ] Tranquilizers [ ] Insulin [ ] Birth control [ ] Other _____

Age of mattress: _____ [ ] Comfortable [ ] Uncomfortable

Are you wearing: [ ] Heel lifts [ ] Sole lifts [ ] Inner soles [ ]Arch supports [ ] None

Have you been in an auto accident? [ ] Past year [ ] Past 5 yrs. [ ] Over 5 yrs. [ ] Never

Describe: _____

Have you had any other personal injury or accident? [ ] Past year [ ] Past 5 yrs. [ ] Over 5 yrs. [ ] None

Describe: _____

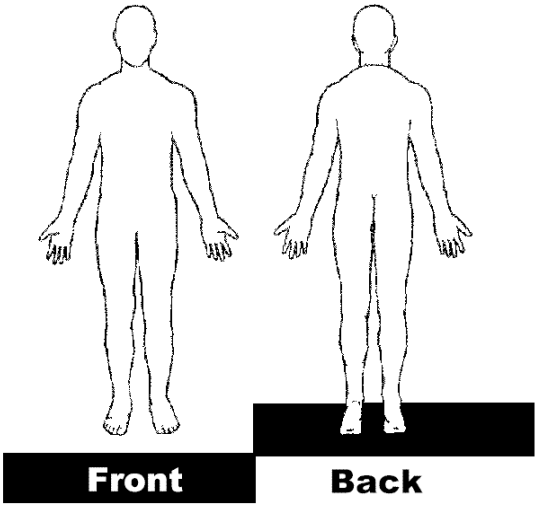
BETHANY RAUDENBUSH, D.C.

Patient Name (printed): _____ **Today's Date: _____**

PAIN DIAGRAM: Please mark your areas of pain on the figures.

TYPES OF PAIN:

B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & needles



HAVE YOU EVER SUFFERED FROM:

[ ] Digestive disorders
[ ] Dizziness
[ ] Diabetes
[ ] Headaches
[ ] Neuritis
[ ] Sinus trouble
[ ] Sleeping problems
[ ] Irritability
[ ] Pins/needles in arm
[ ] Pins/needles in leg
[ ] Numbness in fingers
[ ] Shortness of breath
[ ] Loss of memory
[ ] Loss of smell
[ ] Loss of taste
[ ] Stomach upset
[ ] Cold sweats
[ ] Diarrhea
[ ] Heart trouble
[ ] Backaches
[ ] Arthritis
[ ] Asthma
[ ] Nervousness
[ ] Neck pain
[ ] Tension
[ ] Chest pain
[ ] Fatigue
[ ] Depression
[ ] Ears ring
[ ] Loss of balance
[ ] Fainting
[ ] Feet cold
[ ] Constipation
[ ] Fever

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weakness; thus, information about your family members will give us a better picture of your total health picture.

Name	Relation	Past and Present Health Problems

I clearly understand and agree that all services rendered me are charged directly to me and payment is due when service is rendered and that I am personally responsible for payment.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself and that this chiropractic office does not accept insurance assignment. Furthermore, I understand that this chiropractic office does not prepare and file insurance claim forms with the insurance carrier. I also understand that this chiropractic office will provide me with itemized statements for services rendered that I may use to submit independently with my insurance carrier for determination of benefits payable.

Patient's Signature: _____ Guardian's Signature: _____

Doctor's Signature: _____ Date: _____

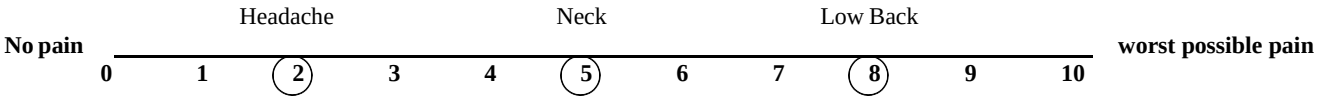
QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name:_____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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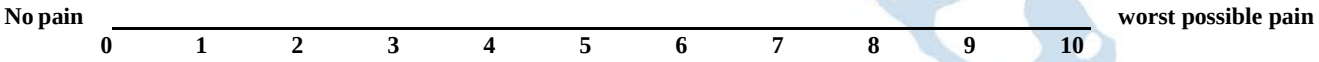
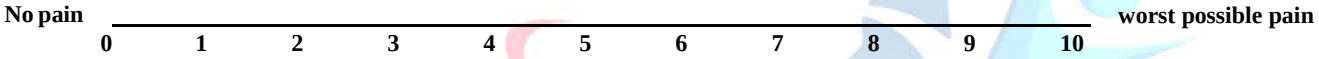
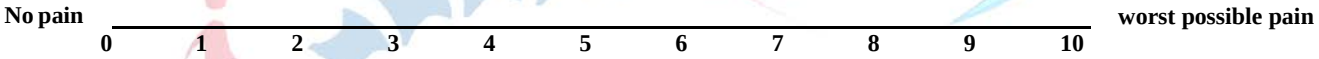
1 – What is your pain RIGHTNOW?



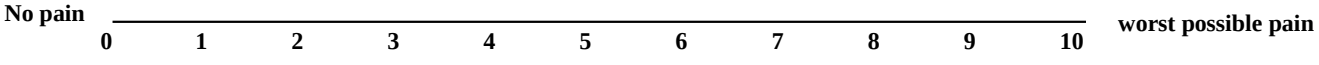
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

_____

_____

_____

Patient's Signature _____ Examiner's Signature _____

Bethany Raudenbush, D.C.

INFORMED CONSENT

- I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
- I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
- I have read, or have had read to me, the above consent. 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.

Patient Name (printed): _____

Patient (or guardian) Signature:_____ Date_____

Witness Signature: _____ Date_____

Doctor's Name (printed): Bethany Raudenbush, D.C.

900 N. Swallowtail Dr. – Suite D-104
Port Orange, FL 32129 e-mail: info@focusforwardchiropractic.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the "*Notice of Privacy Practices*" and that I have read them or declined the opportunity to read them and understand the "*Notice of Privacy Practices*". I understand that this form will be placed in my patient chart and maintained for six years.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

Name	Relationship

AUTHORIZED COMMUNICATIONS PROCEDURES

☐ I understand that e-mail communications are sent via unencrypted methods. I hereby request _ **Bethany Raudenbush, D.C**. _ to communicate with me via e-mail at the following e-mail address: _____ or send postcards and other correspondence via USPS to the address listed in my chart unless otherwise specified here:

☐ I hereby request that _**Bethany Raudenbush, D.C.**_ place all telephone calls or texts to me at the following number/numbers: _____.

☐ I hereby request that **Bethany Raudenbush, D.C.**__ leave no voice mail messages on the above listed or any other telephone listings relating to me.

_____ _____

Patient Name (please print) Parent, Guardian or Patient's legal representative

_____ _____ _____

Patient Date of Birth Signature of Patient or Guardian Today's Date

For Use by Privacy Officer Only

Practice: ____ Accepts _____ Denies Date: _____

Signature of Privacy Officer: _____