Generations Chiropractic
Healthy Lifestyles For All Ages

New Patient Form

Welcome to Generations Chiropractic. To help us provide you with the best possible care, please fill out this form as accurately as possible.

Name:			Birthdate: / /
Street Address:			How do you want reminders?
Mailing Address:			☐ Phone ☐ Text ☐ Email
City:	State:	Zip:	Sex: ☐ Male ☐ Female
Home: ( )	Cell: ( )		☐ Married ☐ Single ☐ Other
Work: ( )	Occupation:		Email:
May we contact you at work? Yes	No		May we email you for appointment reminders? Yes
In case of emergency, contact:			May we leave a message? Yes No
Relationship:			Telephone: ( )
How did you hear about Generations Chiropractic?			
Are you being treated elsewhere?			
For what complaint?			
Personal Physician's Name:			Telephone: ( )
Current Medications:			
Current Supplements:			

Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

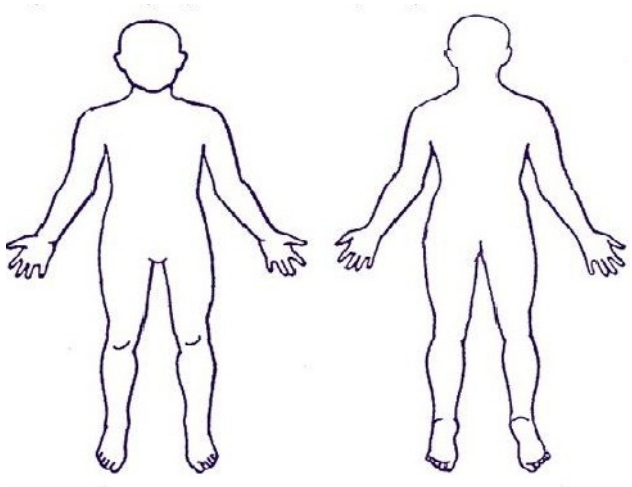
What makes it worse? _____

(Health Concern or Goal #2 cont….)
If pain is associated with your condition, please check all that apply: *Type of pain*
□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning
□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____
How often do you experience this condition? _____
Is it constant or does it come and go? _____
Anything else you feel is important about this condition? _____

Health Concern or Goal #3 *(Please describe as many details as you can)* _____
_____
When did you first notice symptoms appear? _____ Was there a trigger? _____
Is this condition getting: □ Better □ Worse □ About the same
What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____
_____
What makes it better? _____
What makes it worse? _____
If pain is associated with your condition, please check all that apply: *Type of pain*
□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning
□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____
How often do you experience this condition? _____
Is it constant or does it come and go? _____
Anything else you feel is important about this condition? _____

Please indicate any areas of pain or injury. Describe any helpful details as well.

☐ Spasms
☐ Numbness
☐ Swelling/Edema
☐ Bruising/Tenderness
☐ Stiffness
☐ Tingling
☐ Burning
☐ Radiating to
☐ Sudden Onset
☐ Gradual Onset
☐ Constant
☐ Intermittent
☐ Sharp
☐ Dull



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Generations Chiropractic Policy:
All fees for our services are due at the time of visit unless arrangements have been previously approved. If you need to cancel an appointment, please give us a minimum of 24 hours notice. There may be a $25 cancellation fee for less than 24 hour notification. **Initials**:_____

- My signature authorizes Generations Chiropractic to treat me (or the patient for whom I am legally responsible) with the appropriate therapies within the licensure of certification granted by the States of Colorado and Wyoming or other agencies.
- I agree that the doctor will exercise judgment during the course of the procedure which the doctor feels is the best course of action for my treatment, based on the facts as known, and is in my best interest.
- 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.
- I have received the Generations Chiropractic Notice of Privacy Policies (HIPAA Notice).
- **Payment Information** *Payment is due at time of service, no exceptions. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement for a small setup and statement fee.. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.*

Signature:_____ Date:_____
(Patient, Parent, or Guardian)