FLATHEAD CHIROPRACTIC

MOVE WELL. LIVE LIFE.

JOSHUA BORGARDT, DC

17 2nd Street East
Suite 214
Kalispell, MT 59901

NEW PATIENT EXAMINATION

PATIENT INFORMATION

Name _____Preferred Name_____

Gender ☐ M ☐ F Date of Birth _____/_____ /_____ Age _____ Height _____ Weight _____

Address _____

Home Phone_____ Cell Phone_____

Email _____

Occupation & Employer _____

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

Patient's Name: _____ Date: ___/___/___

HISTORY OF CURRENT CONDITION

Describe main complaint (if any):_____

Began when?_____/_____/_____ Describe how it began:_____

Severity of the pain (10 = the worst pain you've ever had): 1 2 3 4 5 6 7 8 9 10

Quality of the pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other:_____

How frequent is the pain? Off & On / Constant

Does this pain radiate to any areas of your body? No / Yes (Describe):_____

Does anything make the complaint better? _____

Does anything make the complaint worse? _____

Which daily activities are being affected by this condition? (*Describe*)_____

For this CURRENT condition, have you:

Received any other treatment? _____

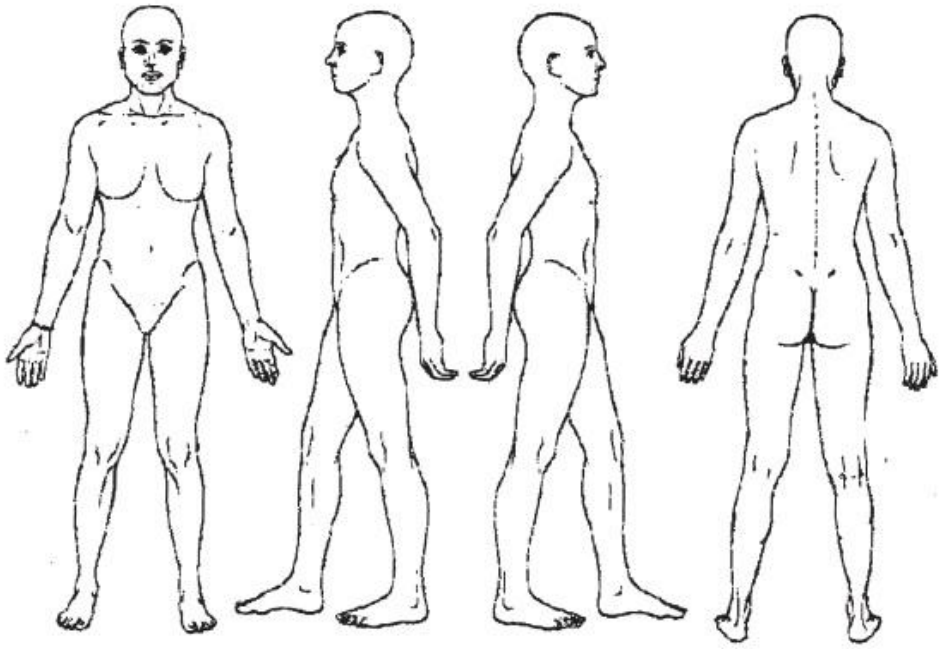
Any previous surgery or intervention in this area?_____

Any medications?_____

Any diagnostic testing? X-Ray / MRI / CT / Other:_____

Describe any secondary complaints:_____

Circle the areas where you have pain…



Patient's Name: _____ Date: ___/___/___

REVIEW OF SYSTEMS

Please check any condition listed below that applies to you:

- □ contagious skin condition
- □ open sores or wounds
- □ easy bruising
- □ recent accident or injury
- □ recent fracture
- □ recent surgery
- □ artificial joint
- □ sprains/strains
- □ current fever
- □ swollen glands
- □ allergies/sensitivity
- □ heart condition
- □ high or low blood pressure
- □ circulatory disorder
- □ varicose veins
- □ pregnancy If yes, how many months? _____
- □ atherosclerosis
- □ phlebitis
- □ deep vein thrombosis/blood clots
- □ joint disorders
- □ osteoporosis
- □ epilepsy
- □ headaches/migraines
- □ cancer
- □ diabetes
- □ decreased sensation
- □ back/neck problems
- □ Fibromyalgia
- □ TMJ
- □ carpal tunnel syndrome
- □ tennis elbow

Please explain any condition that you have marked above:

_____

_____

_____

Patient's Name: _____ Date: ___/___/___

HISTORY OF PAST CONDITIONS

Surgeries:_____

Major Traumas/Injuries:_____

Major Hospitalizations:_____

FAMILY HEALTH HISTORY

List relevant major health problems of immediate relatives:_____

Deaths in immediate family: *(cause and at what age?)*_____

Patient signature: _____ Date: ____/____/____

HIPPA NOTICE

I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If there is anyone you do not want to receive your medical records, please inform our office.

Patient signature:_____

INFORMED CONSENT TO CHIROPRACTIC CARE (Please sign even if you're not getting chiropractic, just in case you do later)

I hereby request and consent to chiropractic adjustments by Flathead Chiropractic's Physicians. I understand and am informed that in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, 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/her, is in my best interest. I understand that results are not guaranteed. 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 signature:_____ **Date:** ___/___/

CONSENT TO TREAT A MINOR (IF APPLICABLE)

I (***full name of legal Parent or Guardian***) _____am the legal parent or guardian of the above patient and consent to chiropractic treatment at Barkley Massage & Chiropractic.

Parent or guardian signature:_____ **Date:** ___/___/