Dry Creek Chiropractic

3300 N Running Creek Way
Bldg. E Ste. 100
Lehi, UT 84043

Phone 801-766-4113
Fax 801-766-4776

New Patient Form

Date _____

First Name _____ Last Name _____

Nickname _____

DOB _____ Birth Sex: ◯ Male ◯Female SSN _____-_____-_____

Address _____ City_____ State _____ Zip _____

Phone 1 _____ Phone 2 _____ Email _____

◯Home ◯Mobile ◯Work ◯Other ◯Home ◯Mobile ◯Work ◯Other

Job Status: ◯Not Employed ◯Employed ◯Retired ◯Student

Marital Status: ◯Single ◯Married ◯Other_____ Are you Pregnant? ◯Yes ◯No

Reason for Visit _____

How Heard of Us:

◯Social Media ◯Google ◯Website ◯Referral Referred by _____

Appointment Reminders: ◯Decline ◯Voice ◯Text ◯Email

Message Contact: ◯Decline ◯Voice ◯Text ◯Email

Demographics

Race:

- ☐ Declines to Specify
- ☐ White
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Hawaiian or Pacific Islander
- ☐ Other

Ethnicity:

- ◯Declines to Specify
- ◯Hispanic or Latino
- ◯Not Hispanic or Latino

Hand Dominance:

- ◯Right
- ◯Left
- ◯Ambidextrous

Gender:

- ◯Male
- ◯Female

Previous Name: _____
(for insurance purposes

Emergency Contact

First Name _____ Last Name _____ Relationship _____

Phone 1 _____ Phone 2 _____

Employment Info

(Workers Compensation Only)

Employer _____ Employer Phone _____ Occupation _____

Primary Care Provider _____

MIST

Medications/Vitamins/Supplements:

Medication_____ Dose_____ Frequency_____ Start Date_____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies:

Allergy_____ Severity_____ Onset_____ ◯Side effect ◯Intolerance ◯Reaction
_____ _____ _____ ◯Side effect ◯Intolerance ◯Reaction
_____ _____ _____ ◯Side effect ◯Intolerance ◯Reaction

Past and Present Illnesses/Disorders:

Illness/Disorder_____ Onset_____ End Date_____ ◯Current ◯Resolved ◯Inactive
_____ _____ _____ ◯Current ◯Resolved ◯Inactive
_____ _____ _____ ◯Current ◯Resolved ◯Inactive

Surgeries:

Surgery_____ Date _____
_____ _____
_____ _____

Traumas:

Trauma_____ Date_____ ◯Current ◯Resolved ◯Inactive
_____ _____ ◯Current ◯Resolved ◯Inactive
_____ _____ ◯Current ◯Resolved ◯Inactive

Daily Habits

Do you smoke? ☐Never smoked ☐Current smoker ☐Former smoker

If yes, how many packs per day?_____ If yes, how many years have you smoked?_____

Daily caffeinated beverages: ☐Unknown ☐None ☐1-3 ☐4-6 ☐7-10 ☐11-15 ☐over 15

Weekly alcoholic beverages: ☐Unknown ☐None ☐1-3 ☐4-6 ☐7-10 ☐11-15 ☐over15

Do you exercise regularly? ☐No ☐Light ☐Moderate ☐Heavy **What is your stress level?** ☐None ☐Low ☐Moderate ☐Severe

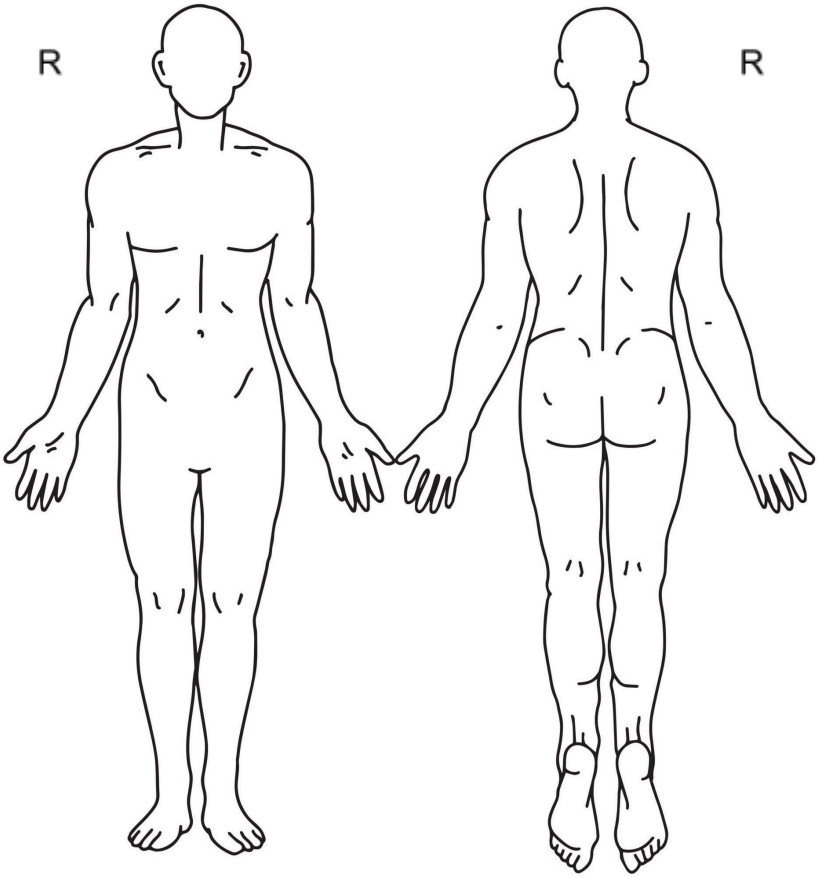
What is your sleep like? ☐Restful ☐Trouble Falling asleep ☐Trouble staying asleep ☐Other:_____

Energy Level: ☐Good ☐Insufficient ☐Erratic

Complaint

Chief complaint: What is your main complaint? _____

Location: Please circle the area(s) where you experience symptoms.



Frequency: How often do you experience pain?

- ☐ Occasional (1-25%)
- ☐ Intermittent (26-50%)
- ☐ Frequent (51-75%)
- ☐ Constant (75-100%)

Onset: When did the symptoms start?

_____

Cause: Do you know what caused the problem?

_____

Compared to when it began, is your condition:

☐ Same ☐ Better ☐ Worse

Intensity: On a scale of 1-10, what is your pain level today? (Circle one)

1 2 3 4 5 6 7 8 9 10

Quality: Describe your pain

☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull
☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore
☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling
☐ throbbing ☐ other:_____

Aggravating Factors: What makes the problem worse?

☐ most movements ☐ bending ☐ eating ☐ exercise
☐ heat ☐ housework ☐ carrying things ☐ lying down
☐ lying to sitting ☐ sitting to standing ☐ ice ☐ massage
☐ sitting ☐ standing ☐ stretching ☐ deep breathing
☐ twisting ☐ walking ☐ other:_____

Does the pain travel anywhere else? ☐ Yes ☐ No If yes, where?_____

Relieving Factors: What makes the problem better?

☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement
☐ painkillers ☐ rest ☐ stretching ☐ walking ☐ wraps ☐ other:_____

What daily activities are affected due to the problem?

☐ caring for children ☐ driving ☐ eating ☐ exercising ☐ hygeine ☐ housework ☐ lifting ☐ sex ☐ sleeping ☐ social/recreational activities
☐ toileting ☐ using technology ☐ walking ☐ working ☐ other:_____

Have you been given a diagnosis for the problem? ☐ Yes ☐ No If yes, what was the diagnosis?_____

What treatments have you tried for your condition?

☐ **None** ☐ **Medication** ☐ **Surgery** ☐ **Physical t**herapy ☐ Chiropractic ☐ Massage Therapy ☐ Other:_____

Review of Systems

Other than your current complaint, what concerns have you experienced in the following systems?

Musculoskeletal: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Cardiovascular/Respiratory: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Head/Neck: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Eyes: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Nose: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Ears: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Throat/Mouth: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Urinary: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Gastrointestinal: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Endocrine: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Vascular/Hematologic: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Neurologic: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Psychiatric: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

Genitourinary or Reproductive: ☐ Never ☐ Previously ☐ Currently ☐ I don't know

If yes, please specify:_____

PAYMENT POLICY

Insurance Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
(insurance company)
and assign directly to the above named clinic all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Insurance Payment Policy

Dry Creek Chiropractic may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Dry Creek Chiropractic.

_____
Print Name of Patient, Parent, Guardian, Representative

_____ Date_____
Signature of Patient, Parent, Guardian, Representative

Relationship to Patient:_____

Cash Payment Policy

I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Dry Creek Chiropractic.

_____
Print Name of Patient, Parent, Guardian, Representative

_____ Date_____
Signature of Patient, Parent, Guardian, Representative

Relationship to Patient:_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

_____
Print Name of Patient, Parent, Guardian, Representative

_____ Date_____
Signature of Patient, Parent, Guardian, Representative

Relationship to Patient:_____

For Office Use Only
We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because: ☐ Individual refused to sign ☐ We were unable to communicate with the patient ☐ An emergency situation prevented us from obtaining Acknowledgement ☐ Other (Please Specify)_____ _____ Staff Signature Date

HIPAA Release

We cannot discuss your protected health information with anyone other than yourself unless you authorize us to do so.

Would you like to share your protected health information with anyone?

☐ No
☐ Yes, I would like to fill out the form

AUTHORIZATION FOR EMAILS AND TEXT MESSAGING
(SMS COMMUNICATIONS)

Patient Name_____ Date of Birth:_____

I understand that:

- Text messages are inherently insecure because they are transmitted over a public network onto a personal telephone and such there are inherent risks in using this type of communication. Information texted to me could be received and reached by an unauthorized third party.
- It is my responsibility to keep my mobile number and email up to date with Dry Creek Chiropractic.
- I should not send protected health information to Dry Creek Chiropractic in a text message because of the unsecure nature of text messages.
- Emails may be sent unencrypted and contain protected health information which incurs the inherent risk of an unauthorized personal reading the email.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Dry Creek Chiropractic to send text messages to the following mobile number: _____ and emails to the following email:_____ for the following:
    - Notify me of appointment confirmations, reminders or missed appointments
    - Scheduling of upcoming appointments and cancellations
    - Informing me that results are back (actual results will NOT be sent)
    - Promotional material and office updates
    - Other _____
- Dry Creek Chiropractic will not send protected health information or sensitive information in a text message.
- Dry Creek Chiropractic can send protected health information or sensitive information through email according to patient authorization.
- If I sign this authorization, I may revoke (cancel or opt out) later at any time by either contacting us or opting out by sending STOP to our text messages.
    - If you send STOP at any time, for any message, you will no longer receive any text messages from Dry Creek Chiropractic including appointment reminders.
- If I sign this authorization for emails, I may revoke later at any time through writing.

I authorize the use of

⬜Text Messaging ⬜Emails ⬜Do not text or email me

_____ Date_____

Signature of Patient, Parent, Guardian, Representative

_____ Relationship to Patient:_____

Print Name of Patient, Parent, Guardian, Representative