O'Malley Family Chiropractic NEW PATIENT Evaluation

Date:_____

Print Name:_____ Date of Birth:_____

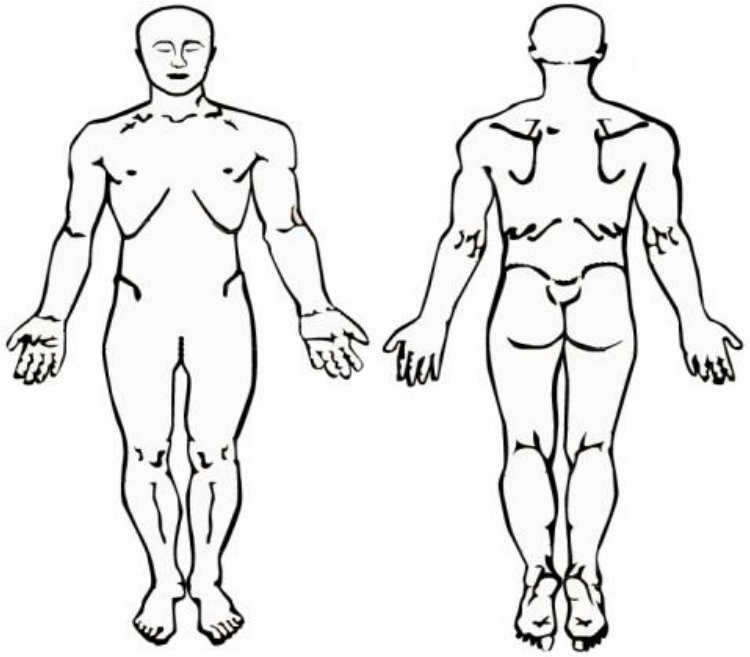
Primary Tel: _____ H / W / C Email:_____

Emergency contact:_____ phone number:_____

Is this condition due to a: **___ Car Accident ___ Work-related ___ Neither of these**

**Circle the area of pain. **

**Is it on the left or right side? **



How **severe** is the pain?

1
2
3
4
5
6
7
8
9
10

Is the pain sharp, achy, stiff, tight sore, tense, numb, tingling, or other.

_____

When did these symptoms begin? _____

What makes the pain better? _____

What makes the pain worse? _____

Other practitioners seen: _____

What medical conditions do you have?_____

What medications/vitamins do you take? _____

Past surgeries/Injuries: _____

Recent tests/x-rays/MRI:_____

Current Exercise/walking program:_____

Women: Pregnant Yes No

Anything else you would like us to know:_____

Signature: _____ Date:_____

Appointment Cancellation/Rescheduling Policy

We require a 12-hour notice to cancel or reschedule an appointment. We do not overbook our appointment slots so we can provide you with the best possible care. This policy, based on mutual respect, ensures that enough notice is given so that we may offer that time slot to another person.

To help ensure clarity of communication, please <u>initial</u> the following:

____ I acknowledge that I was presented with a copy of the **Notice of Privacy Practices** to read on my initial visit which describes the types and uses and disclosures of my protected health information.

____ I acknowledge that my health history will not be shared without my written consent. A **Release of Medical Records** will have to be signed in order for records to be received or sent.

____ I acknowledge my understanding of the Appointment Cancellation Policy and agree to receive appointment reminders by Text or phone to help ensure that appointments are kept. I understand that missed appointments or late cancellations are subject to a $45.00 charge that is **not billable to Medicare or other health insurances.**

Patient Signature: _____ Date: _____