New Practice Member Application

Name: ______________________________ Date of Birth: ____/____/____ Age: ______ Gender: M/F

Address: ______________________________ City: ______________ State: ________ Zip: ____________

Phone Number: ________________________ Email: ______________________________

Occupation: ________________________ Employer: ______________________________

Status: **Single/Married/Divorced/Widowed** Social Security #: ______________________________

# of Children: _____ Names & Ages: ______________________________

Spouse's Name: ____________________ Who may we thank for referring you? ____________________

Name & Number of Emergency Contact: ________________________ Relationship: ______________

Insurance Information

(Please give your insurance card and driver's license to the front desk for a complimentary insurance benefits check)

Primary Insurance Carrier: ____________________ Subscriber's Name: ________________________

Occupation: ____________________ Employer: ________________ Date of Birth: ____/____/____

List The Heath Concerns That Brought You Into This Office

	Health Concerns List According To Severity ↓	Rate of Severity 0 = No Pain 10 = Unbearable	When Did This Problem Start?	Have You Had the Problem Before? If So, When?	Did The Problem Begin With an Injury?	Are Symptoms Constant (C) Or Intermittent (I)?
Primary:	__________	________	____________	____________	____________	____________
Second:	__________	________	____________	____________	____________	____________
Third:	__________	________	____________	____________	____________	____________
Fourth:	__________	________	____________	____________	____________	____________

Release of Authorization/ Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to the doctors. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by my insurance.

Signature: ____ Date: ________________

"The Power that Made the Body Heals the Body." -B.J. Palmer

Patient Name: ___________________________________ HR #: _______________________ Date: ____ /____ /____

Please Mark "**P**" for in the Past OR Mark "**C**" for Currently Have:

___ Headache	___ Ear Infection	___ Sinus Issues	___ Kidney Problems	___ Migraines
___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems	___ Diabetes
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___ Seizures	___ Tight/ Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___ Scoliosis	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Joint Pain
___ Upper Back Pain	___ Double/ Blurry Vision	___ Nausea	___ Epilepsy/ Convulsions	___ Gerd/ Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/ Hands
___ Lower Back Pain	___ ADD/ ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/ Tingling in Legs/ Feet
___ Hip/ Leg Pain	___ Loss of Balance	___ Diarrhea	___ Menstrual Problems	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ Difficulty Breathing
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Prostate Problems

Other: ____

Please Mark "**P**" for in the Past OR Mark "**C**" for Currently Have:

____ STROKE ____ CANCER ____ HEART ATTACK ____ SPINAL SURGERY ____ SEIZURES ____ SPINAL BONE FRACTURE

____ SCOLIOSIS ____ DIABETES ____ OSTEOARTHRITIS ____ RHEUMATOID ARTHRITIS ____ OTHER CONDITIONS/DISEASES

LIST ALL SURGICAL OPERATIONS AND YEARS: ____

LIST ANY OTHER INJURIES TO YOUR SPINE, MINOR OR MAJOR, THAT THE DOCTOR SHOULD KNOW ABOUT:

____

WHEN WAS YOUR LAST AUTO ACCIDENT? ____

HAVE YOU EVER BEEN KNOCKED UNCONSIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES TO EITHER OF THE ABOVE, PLEASE DISCRIBE: ____________________________________

OTHER TRAUMA: ____

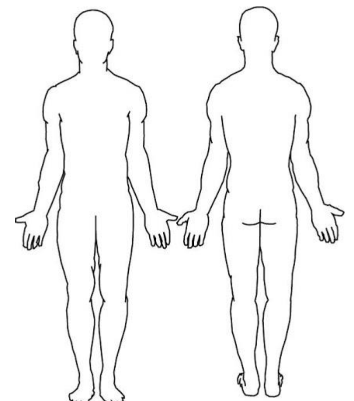
____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YES, DR. & DATE: ____

SOCIAL HISTORY

1. Have you consumed any caffeine products in the past 48 hours? ☐ Yes ☐ No
2. Alcohol: How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
3. Exercise: How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never
4. Smoking: How Often? ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never



PLEASE MARK the areas on the diagram with the following letters to describe your symptoms:
R= Radiating **B**= Burning **D**= Dull **A**= Aching **N**= Numbness **S**= Sharp/Stabbing **T**= Tingling

What relives your symptoms? ____

What makes them feel worse? ____

"There is a Vast Difference between Treating Effects and Adjusting the Cause." -D.D. Palmer

Quadruple Visual Analogue Scale (QVAS)

Please circle the number that best describes the question asked. If you have more than one complaint, please answer for each individual complaint and indicate the score for each complaint.

EXAMPLE

1. How would you rate your pain right now?

2. What is your typical AVERAGE pain?

3. What is your pain level at its BEST? (how close to 0 does your pain get at its best)

What percentage of your awake hours is your pain at its best? ______%

4. What is your pain level at its WORST? (how close to 10 does your pain get at its worst)

What percentage of your awake hours is your pain at its worst? ______%

Practice Member Name: ____ Date: ________________

Score: Q1_____ + Q2_____ + Q4_____ = _____ / 3x10 = _____ (low intensity = <50; high intensity >50)

“The Preservation of Health is Easier than the Cure of Disease.” -B.J. Palmer

Patient Name: ______________________________ HR #: ____________________ Date: ____ /____ / ____

Activities of Daily Living

Please Identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activity:	**Effect:**			
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sweeping/Vacuuming	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dishes	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Laundry	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Garbage	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration (Reading)	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: ____________	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Restricted Activity	**Current Activity Level**	**Usual Activity Level**
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Doctor Signature: ______________________________________ Date ____ /____ /____

"Chiropractic, like Gravity, Works whether you Believe it or Not." -Sid Williams, D.C.

Patient Name: ____________________________________ HR #: ________________________ Date: ____ /____ /____

Family Health History

This form is to assist the doctors by providing past health history information for their review. Please mark with an "X" if any of the following applies to your family.

Condition	Spouse	Son	Daughter	Mother	Father
Headaches					
Neck Pain					
Jaw/TMJ Pain					
Dizziness					
Hearing Loss					
Blurred/Double Vision					
Allergies					
Sinus Issues					
Loss of Energy					
Anxiety					
Depression					
Thyroid Problems					
Shoulder Pain					
Back Pain					
Hip/Leg Pain					
Sciatica					
Arthritis/Joint Pain					
Asthma					
Breathing Problems					
Heart Problems					
High Blood Pressure					
Stomach Problems					
Bed Wetting					
Infertility					
Fibromyalgia					
Poor Posture					
Sleep Problems					
Stroke					
Cancer					
Heart disease					
Diabetes					
Alzheimer's					

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain of muscles, irritation of a disc condition, and rarely, rib fractures. One of the rarest complications associated with chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) twisting adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another healthcare provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Print Name: ____

Signature: ______________________________ Date: ______________

If this health profile is for a minor please fill out and sign below

Written Consent for a Minor

Name of practice member who is a child/minor: ______________________________

I authorize Dr. MacKenzie Ryczek, Dr. Nick Ryczek, and any and all New Wave Chiropractic team members to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my child/minor. As of this date, I have the legal right to select and authorize healthcare services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify New Wave Chiropractic.

Guardian Signature: ______________________________ Date: ___________

Relationship to Minor: ______________________________

Did You Know: Torque Release Technique is the MOST Researched Chiropractic Technique?

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments to the spine.

HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease or illness.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method of practice is delivering specific chiropractic adjustments to correct vertebral subluxations.

I, ______________________________ have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: ____ Date: ____________________

Notice of Privacy Practices Acknowledgment

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: ____ Date: ____________________

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays onto a disc is $10. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of prepayment on any regular practice day of operation. Please Note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctors of New Wave Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical treatment.

By signing below, you are agreeing to the above terms and conditions.

Print Name: ____ Date of Birth: _______________

Signature: ____ Date: ________________

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at New Wave Chiropractic.

Signature: ____ Date: __________

Photo Release

I grant New Wave Chiropractic and its employees the right to take photographs of me with connection to the promotion of chiropractic via website, social media, and any other avenue. I agree that New Wave Chiropractic may use such photographs of me and for any lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

I am at least 18 years of age and have read and understand the above:

Signature: ____

If under 18 years of age, the legal guardian or parent has read and understands the above:

Parent/Guardian Signature: ____

Doctor Signature: ____ Date: ___________

Did You Know: The First Chiropractic Adjustment Occurred in 1895?