Patient Name:_____

113 W. Lockwood Ave, Webster Groves MO 63119
314-962-6015
www.LockwoodChiropractic.com

NEW PATIENT FORMS

Please complete these pages as accurately as possible.

Legal Name (First & Last): _____ MI: _____ Today's Date: _____

Date of Birth: _____ Male____Female____ Height:_____ Weight:_____lbs

Home Address: _____

City / State / Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address: _____

Please indicate how we may contact you:

YES! you may contact me via ☐ Phone ☐ Mail ☐ E-mail ☐ Text *(carrier charges may apply)*

We will NEVER sell or share your personal information with anyone without your express, written consent. By indicating your choice above, we may send you information and/or offers via mail, e-mail and/or text.

Work Information

Employer:_____ Occupation:_____

Employer's Address:_____

Status: Full Time____ Part Time____ Unemployed____ Retired_____ Student: Full time____ Part Time____

Insurance Information

Insurance Company: _____ ID# _____ Group#_____

Subscriber's Name on Card: _____ ***Subscriber's DOB***:_____

_____

How did you hear about us? Can we thank anyone for referring you?

Referred by: _____

FaceBook ☐ Google ☐ Yelp ☐ Internet Search:_____

Other: _____

_____

Emergency Contact Information:

Name: _____Relationship:_____

Phone: _____ Work/Home/Cell (please circle)

Patient Name:_____

PRESENT HEALTH CONCERNS

Problem and Date of Onset	Previous Treatment or Care	Provider

Primary Care Physician: _____

Other Physicians: _____

Date of last complete physical exam: _____ Date of most recent lab/blood tests:_____

Have you had any X-Rays, MRI's or CT Scans? Date and place:

_____

_____

WOMEN:

Date of last PAP smear:_____ Results:_____ Currently Pregnant: Y / N / UNSURE

_____

Are you visiting today due to: Please Circle

Motor Vehicle Accident? Yes No Workplace Injury? Yes No Legal Site? Yes No

_____

Please list prescription medications, non-prescription medications, and health supplements (e.g., vitamins, minerals, herbs) you are currently taking.

NAME of Med/Supp.	DOSE and FREQUENCY	DURATION: Been taking for how long?

Patient Name:_____

Please list all food, environmental, and/or drug allergies:

Please list previous medical procedures, surgeries, hospitalizations, and serious illnesses with an approximate date and year.

Surgery	Hospitalization	Serious Illnesses	Injuries

HABITS and LIFESTYLE

Please circle all that apply to current or previous use:

Tobacco/Cigarettes	Cola/Soda	Prescription Drugs
Alcohol	Aspirin/Tylenol/Analgesics	Coffee
Antacids	Tea	Recreational Drugs

DIET: Do you follow any particular diet regimens or restrictions?

EXERCISE: Do you exercise regularly? Please Circle. YES NO

If YES: What do you do and how often? _____

If NO: What keeps you from exercising? _____

What goals would you like to accomplish through Chiropractic care?

Patient Name:_____

What questions do you have for today's visit?

REVIEW OF SYSTEMS

For each of the conditions listed below, place a check in the *Past* column if you have had the condition in the past. If you are presently dealing with the condition listed, place a check in the *Present* column.

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

☐	☐
☐	☐
☐	☐

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

Patient Name:_____

Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

_____

Print Patient's Name

_____ Date:_____

Signature of Patient/Parent/Guardian

Financial Policy

Thank you for choosing Lockwood Chiropractic as your health care provider. We are committed to your treatment being successful. The following is our financial policy, which we require you read and sign prior to treatment.

Payment Terms:

Fees for services rendered are due at time of service. We are will file with your PRIMARY INSURER when we are contracted as an "in-net provider" with that insurer. Services performed that are in-network will require payment as negotiated with each individual contract. Lockwood Chiropractic is **not responsible for filing claims with secondary insurers** except in the case of Medicare.

Certain services provided by the doctors and therapists at Lockwood Chiropractic are not reimbursable by your insurance company regardless of network status. Charges include but are not limited to supplements, essential oils, rehab training, nutritional assessment, kinesio taping, acupuncture, and therapeutic massage. The charges for these services will be your responsibility. FSA / HRA funds are accepted.

I understand that certain services are not reimbursable by my insurance. I understand that any such charges will be fully disclosed to me prior to treatment by doctor or staff and that I will pay for such services as rendered.

_____ Date:_____

Signature of Patient or Responsible Party

24-Hour Cancellation / No-Show Policy

Your appointment time is reserved especially for you. Any patient failing to appear at their scheduled time or failing to call 24 hours in advance to cancel/reschedule their appointment will incur a $25.00 fee per service/practitioner scheduled on that day. Any patient appearing 15 minutes or more after their scheduled appointment time, will be seen at the Doctor's and/or Therapist's discretion and a $25.00 fee may apply.

_____ Date:_____

Signature of Patient or Responsible Party

Patient Name:_____

113 W. Lockwood Ave, Webster Groves MO 63119

Informed Consent to Chiropractic Care

When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the know benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors, we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.
Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning, or during, the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend further testing or refer you out to another health care provider.
Chiropractic care has been proven to be very safe and effective. It is not unusual, however, to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction.

I have read and fully understand the above statements and therefore accept chiropractic care, provided by the practitioners of Lockwood Chiropractic, on this basis.

_____

Print Name Signature Date

Consent to Evaluate and Adjust a Minor

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____

Print Name Signature Date

(Rev:2018)