



## NEW PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Secondary Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social: \_\_\_\_\_  
Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_  
Referral Source: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### HISTORY

Chief Complaint: \_\_\_\_\_

Where is your pain located: \_\_\_\_\_

Describe your Pain:

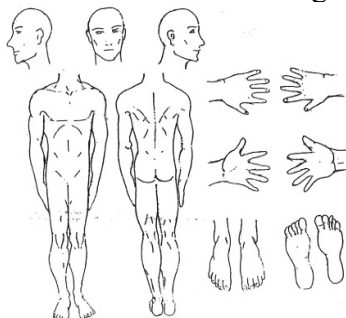
- |                                   |                                     |                                |                                   |                                   |
|-----------------------------------|-------------------------------------|--------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Burning    | <input type="checkbox"/> Achy  | <input type="checkbox"/> Twisting | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Deep     | <input type="checkbox"/> Dull       | <input type="checkbox"/> Heavy | <input type="checkbox"/> Gnawing  | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Electric | <input type="checkbox"/> Knife like |                                |                                   |                                   |

**How severe is your pain?**

- ☐ 0 Absent (no pain)  
☐ 1-2 Tolerable (tolerate without medication)  
☐ 3-4 Bearable (some activities)  
☐ 5-6 Nearly intolerable (sedentary: watch tv, reading, sitting)  
☐ 7-8 Intolerable (Can not read, watch TV, need to visit ER)  
☐ 9-10 Devastating (need hospitalization for pain control)

Please Mark the figure with the location of your symptoms:

Pain=X      Numbness/Tingling= O



How long have you had your pain: \_\_\_\_\_  
 When do you have your pain: \_\_\_\_\_  
 What makes your pain worse: \_\_\_\_\_  
 Are you having difficulty with sleeping because of your pain:      Y                      N  
 How long can you:                      Sit \_\_\_\_\_  
                                                  Stand \_\_\_\_\_  
                                                  Walk \_\_\_\_\_  
 Have you lost any control over bowel or bladder function:                      Y                      N  
 Is your pain related to a specific injury:                      Y                      N  
     if yes please explain: \_\_\_\_\_  
 Is the injury/pain motor vehicle related:      Y                      N  
     if yes, date of injury \_\_\_\_\_  
 Is injury/pain work related:                      Y                      N  
 Is there a lawsuit (pending or considered):                      Y                      N  
 Have you had any physical therapy (PT):                      Y                      N  
     How many sessions? \_\_\_\_\_  
     Has PT helped?                      Y                      N  
 Have you been treated by other clinicians for this problem: Y                      N  
     If yes, please list name, date seen, and treatment given: \_\_\_\_\_  
     \_\_\_\_\_  
 Have you had epidural or facet injections:                      Y                      N  
     How many \_\_\_\_\_ Did they help: \_\_\_\_\_  
 Have you had a previous back or neck injury:                      Y                      N  
 Have you had diagnostic test performed:  
☐ CT              ☐ EMG              ☐ XRAY              ☐ Other: \_\_\_\_\_  
 What do you hope/wish we can accomplish today: \_\_\_\_\_  
 \_\_\_\_\_

#### WORK HISTORY

Are you working:                      Y                      N  
     ☐ Full Time              ☐ Part Time ☐ Restricted Duty: \_\_\_\_\_  
     ☐ Unemployed/Date last worked: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
     How long: \_\_\_\_\_

#### MEDICATIONS

List all medications that you *currently* take: \_\_\_\_\_  
 List any medications that you have *previously* taken and if they did or did not help: \_\_\_\_\_  
 Medicine Allergies:                      Y                      N  
     Please list: \_\_\_\_\_

## PAST MEDICAL HISTORY

Please check the boxes that apply

- |                                                  |                                               |
|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Psychiatric Problem     | <input type="checkbox"/> Pulmonary Embolism   |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Thyroid Disorder     |
| <input type="checkbox"/> Seizure Disorder        | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> GERD                 |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> Gout                    | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Anxiety              |
| <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Heart Murmur         |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Psoriasis               | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Heart Attack         |
| <input type="checkbox"/> Bleeding Disorder       | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Muscle Disease          | <input type="checkbox"/> Migraines            |
| <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Other:_____          |

Are you pregnant? Y/N      If so, how many weeks?\_\_\_\_\_

## PAST SURGICAL HISTORY

List any previous surgeries:\_\_\_\_\_

## FAMILY HISTORY

Please list any medical illness that the following blood relatives have history of

**Grandparents:**\_\_\_\_\_

☐ Living      ☐ Deceased

**Father:**\_\_\_\_\_

☐ Living      ☐ Deceased

**Mother:**\_\_\_\_\_

☐ Living      ☐ Deceased

**Brother/Sister:**\_\_\_\_\_

☐ Living      ☐ Deceased

## SOCIAL HISTORY

**Marital Status:**

☐ Single    ☐ Married      ☐ Divorced    ☐ Separated      ☐ Widow

**Number of Children:**\_\_\_\_\_

Ages:\_\_\_\_\_

**Do you smoke:**      **Y**      **N**

How much:\_\_\_\_\_

How long:\_\_\_\_\_

**Previous smoker:**      **Y**      **N**

When did you quit:\_\_\_\_\_

**Do you drink:**      **Y**      **N**

How many drinks per week:\_\_\_\_\_

**Do you use recreational drugs:**      **Y**      **N**

If yes, what type:\_\_\_\_\_

**REVIEW OF SYSTEMS**  
Please check all that apply

**Constitutional**

- ☐ Fever    ☐ Chills    ☐ Fatigue    ☐ Night Sweats  
☐ Unexplained weight loss/gain    ☐ None

**Skin**

- ☐ Rashes    ☐ Nail Changes    ☐ Easy Bruising    ☐ Color Changes  
☐ Jaundice    ☐ Infections    ☐ None

**Eyes/Ears/Nose/Throat**

- ☐ Vision Changes    ☐ Hearing Loss    ☐ Dizziness/Vertigo  
☐ Ringing in the ear    ☐ Hoarseness    ☐ Difficulty Swallowing  
☐ Discharge/Drainage    ☐ None

**Cardiovascular**

- ☐ Chest Pain    ☐ Palpations    ☐ Leg Swelling    ☐ None

**Respiratory**

- ☐ Coughing up blood    ☐ Wheezing    ☐ Shortness of Breath  
☐ Cough    ☐ Sputum    ☐ Production    ☐ Recent Infection  
☐ None

**Gastrointestinal**

- ☐ Abdominal pain    ☐ Vomiting with Blood    ☐ Nausea  
☐ Blood in Stool    ☐ Constipation    ☐ Diarrhea    ☐ None

**Genitourinary**

- ☐ Painful Urination    ☐ Blood in urine    ☐ Venereal Disease  
☐ Difficulty urinating    ☐ Sexual problems    ☐ Menstrual Problems  
☐ Pregnant    ☐ Menopausal    ☐ None

**Musculoskeletal**

- ☐ Joint swelling    ☐ Stiffness    ☐ Cramping  
☐ Infection    ☐ None

**Endocrine**

- ☐ Changes in urination    ☐ Changes in heat or cold tolerance  
☐ Changes in appetite/thirst/sweating    ☐ None

**Psychiatric**

- ☐ Depression    ☐ Anxiety    ☐ Suicidal Thought  
☐ Mood Changes    ☐ None

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Patient Signature

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Physician Signature

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Date

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Date

# Consent to Use and Disclosure of Protected Health Information

## Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Bates Chiropractic or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

## Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

## Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

## Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

## Reservation of Right to Change Privacy Practice

This office reserves the right to modify the privacy practices outlined in the Notice.

## Signature

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

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Name of Patient (Print)

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Signature of Patient

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Date

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Signature of Patient Representative

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Relationship of Patient Representative to Patient

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Office Representative

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Date

## OFFICE POLICY ON FEES AND INSURANCE CLAIMS

If, by mutual agreement, we are filing your insurance, we need to inform you that you are entering a relationship with the doctor in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for that treatment. The insurance company has no relationship with the doctor. If we contact your insurance company and are informed that insurance benefits are available for the treatment recommended, we will file your claim for you. We are responsible only to file your claim and answer any medical questions they may have.

**Insurance companies give estimates and benefits over the telephone, but these are only estimates and are not always accurate nor a guarantee of payment. You will be responsible for your yearly deductible, co-payment and/or co-insurance and the portion of the charges your insurance carrier does not cover or lists as a "non covered" expense. If your insurance company does not pay, your bill is due and payable immediately.**

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Name (please print)

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Date

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Signature of Responsible Party

## ASSIGNMENT AND RESPONSIBILITY

I hereby assign to Dr. Bates all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my insurance company. I further permit a copy of this authorization to be used in place of the original. **I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.** If the insurance company does not pay, I understand the balance is due immediately and agree to pay in full.

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Signature of Responsible Party

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Date

## OUT OF NETWORK

I understand if Dr. Bates is not preferred providers for my insurance company and that out of network benefits will apply. This may include, but not limited to, such things as a deductible, higher deductible and/or higher co-pay, reduced benefits.

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Signature of Responsible Party

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Date

## NON-INSURANCE PATIENTS

I understand that I will be responsible for all services rendered and will pay at the time of service in full.

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Signature of Responsible Party

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Date

## ACKNOWLEDGEMENT FORM

I acknowledge that Bates Chiropractic and Sports Therapy “Notice of Privacy Practices” has been provided to me.

I understand I have a right to review Bates Chiropractic Notice of Privacy Practices prior to signing this document. Bates Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of Bates Chiropractic, The Notice of Privacy Practices for Bates Chiropractic website at [www.bateschiroport.com](http://www.bateschiroport.com). This Notice of Privacy Practices also describes my rights and Bates Chiropractic duties with respect to my protected health information.

Bates Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Bates Chiropractic website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

Date

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Name of Patient or Personal Representative (Print)

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Description of Personal Representative's Authority

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Name of Privacy Officer

## CANCELLATION/ NO SHOW POLICY AGREEMENT

Bates Chiropractic and Sports Therapy is committed to providing all of our patients exceptional care. When a patient does not show after confirming or cancels without giving enough notice, they prevent another patient from being seen.

**Please call us at (318) 220-8753 or text us at (318) 379-4229 within 24 hours notice on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call or text us by 12:00pm on Friday. If prior notification is not given, you will be charged a \$25.00 for the missed appointment.**

Please sign below to consent to these terms.

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Signature of patient or Responsible party

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Date

## CONSENT FOR TREATMENT

Health care provider are required to advise patients of the nature of the treatment to be provided, the risks, and the benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

- a. While rare, some patients have experienced rib fractures or muscle and ligament sprain/strains following treatment.
- b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches, and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associate with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

- a. The condition that the treatment is to address
- b. The nature of the treatment.
- c. The risk and benefits of that treatment; and
- d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatment offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all present and future care with **Bates Chiropractic & Sports Therapy.**

Dated this \_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
Signature Patient Name (Legal Guardian)

\_\_\_\_\_  
Signature of Witness

Print Name

Print Name