

Lincoln Chiropractic

Consent to Initiate Care

At our office, we have one simple goal~ We want to render the highest quality Chiropractic care at the lowest possible fee. In order to accomplish this goal, we have altered some of our business procedures to keep our fees reduced. Please read over the procedures as stated below to understand how our office functions, and to decide if you wish to participate. If you have any questions, please feel free to ask. Thank you.

- ❖ You may choose to submit receipts to your insurance company or other third -party health care programs, but payment for such services by insurance companies is neither implied nor agreed to by this office. We take *no responsibility* for non-payment by insurance companies for services rendered at our office.
- ❖ Our office will *not respond* to any requests for paperwork for insurance purposes or even acknowledge insurance requests for information on any patient's case. Patients however may have a copy of their records.
- ❖ No balances can be kept or run by patients at any time.
- ❖ All initial new patient visits and existing patient adjustment visits are to be paid for on the day of the service being rendered.
- ❖ Our office reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served.

I wish to initiate care at this office. I have read and understand the Consent to Initiate Care and agree to all terms. I understand that I am under no obligation to receive or continue care.

Print your name: _____

Sign your name: _____

Date: _____

Parental Consent to Evaluate and Treat a Minor

I, _____, being the parent/legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Witness Signature: _____

Adult Patient Questionnaire

Confidential Patient Information

First Name:	Last Name:	Date:
SSN:	DOB:	Sex:
Occupation:	# of Children:	Marital Status:
Street Address:		Height:
City, State, Postal Code:		Weight:
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emergency Relation:	Emergency Phone:
How did you hear about us?		
Who is your primary care physician?		
Date and reason for your last doctor visit?		
Are you receiving care from any other health professionals? <input type="radio"/> Yes <input type="radio"/> No – If yes, please name them and their specialty:		
Please note any significant family medical history:		

Current Health Conditions

What health condition(s) bring you into our office?

Have you received care for this problem before? Yes No

– If yes, please explain:

When did the condition(s) first begin?

How did the problem start? Suddenly Gradually Post-Injury

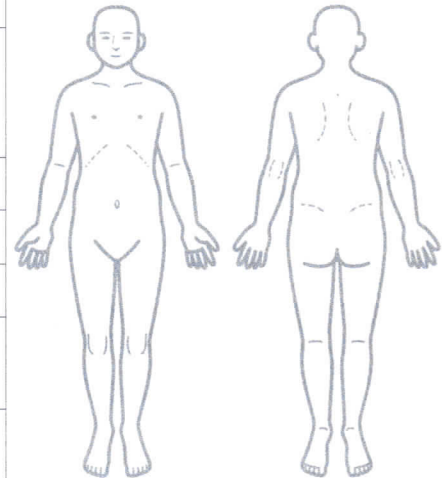
Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.

X=Current condition; O=Past condition



Your Health Goals

What are your top three health goals?

1. _____

2. _____

3. _____

Chiropractic History

What would you like to gain from chiropractic care? Resolve existing condition(s) Overall wellness Both

Have you ever visited a chiropractor? Yes No – If yes, what is their name?

– What is their specialty? Pain Relief Physical Therapy & Rehab Nutrition Subluxation-based Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? Yes No

– If yes, please explain:

Notable childhood injuries? Yes No – If yes, please explain:

Youth or college sports? Yes No – If yes, list major injuries:

Any past auto accidents? Yes No – If yes, please explain:

How often do you exercise? None 1-3x per week 4-6x per week Daily

– What types of exercise?

How do you normally sleep? Back Side Stomach Do you wake up: Refreshed and ready Stiff and tired

Do you commute to work? Yes No – If yes, how many minutes per day?

List any problems with flexibility (*ex. putting on shoes/socks, etc*):

How many hours per day do you typically spend sitting at a desk? On a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Alcohol	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Water	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugar	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Dairy	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Gluten	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Processed Foods	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Artificial Sweeteners	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Sugary Drinks	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Cigarettes	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Recreational Drugs	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs or other that you are taking and why:

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None					Moderate					High				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Home	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Work	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Life	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Money	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Health	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
Family	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5

Acknowledgement & Consent

Patient Signature: _____

Date: _____

Dr. Herbert Curtis Jr., DC, MS | Lincoln Chiropractic
 132 Old River Road Suite #105 Lincoln, RI 02865 | 401-334-3900 | www.LincolnChiro.net

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT		
 Cervical	<ul style="list-style-type: none"> Autonomic Nervous System ENT System Vision, Balance & Coordination Speech Immune System Digestive System Nerve Supply to Shoulders, Arms & Hands Sympathetic Nucleus Metabolism 	<input type="checkbox"/> Colic & Excessive Crying <input type="checkbox"/> Ear & Sinus Infections <input type="checkbox"/> Allergies & Congestion <input type="checkbox"/> Immune Deficiency <input type="checkbox"/> Headaches & Migraines <input type="checkbox"/> Vertigo & Dizziness <input type="checkbox"/> Sore Throat & Strep <input type="checkbox"/> Swollen Tonsils & Adenoids <input type="checkbox"/> Vision & Hearing Issues <input type="checkbox"/> Low Energy & Fatigue <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> Epilepsy & Seizures <input type="checkbox"/> Sensory & Spectrum <input type="checkbox"/> ADD / ADHD <input type="checkbox"/> Focus & Memory Issues <input type="checkbox"/> Anxiety & Stress <input type="checkbox"/> Balance & Coordination <input type="checkbox"/> Speech Issues <input type="checkbox"/> TMJ / Jaw Pain <input type="checkbox"/> Stiff Neck & Shoulders <input type="checkbox"/> Depression <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Poor Metabolism & Weight Control		
	Upper Thoracic	<ul style="list-style-type: none"> Upper G.I. Respiratory System Cardiac Function 	<input type="checkbox"/> Reflux / GERD <input type="checkbox"/> Chronic Colds & Cough <input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis & Pneumonia <input type="checkbox"/> Functional Heart Conditions	
		Mid Thoracic	<ul style="list-style-type: none"> Major Digestive Center Detox & Immunity 	<input type="checkbox"/> Gallbladder Pain / Issues <input type="checkbox"/> Jaundice <input type="checkbox"/> Fever	<input type="checkbox"/> Indigestion & Heartburn <input type="checkbox"/> Stomach Pains & Ulcers <input type="checkbox"/> Blood Sugar Problems
			Lower Thoracic	<ul style="list-style-type: none"> Stress Response Filtration & Elimination Gut & Digestion Hormonal Control 	<input type="checkbox"/> Behavior Issues <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Chronic Stress
	Lumbar, Sacrum & Pelvis			<ul style="list-style-type: none"> Lower G.I. (Absorption & Motility) Gut-Immune System Major Hormonal Control 	<input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's, Colitis & IBS <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bed-wetting <input type="checkbox"/> Bladder & Urination Issues <input type="checkbox"/> Cramps & Menstrual Issues <input type="checkbox"/> Cysts & Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Impotency <input type="checkbox"/> Hemorrhoids

Patient Name: _____ Date: ____ / ____ / ____