



## NEW PATIENT INFORMATION

**Welcome!** Please allow our staff to photocopy your driver's license, insurance, and Medicare card (if applicable.)

PLEASE PRINT CLEARLY.

Date:

\_\_\_\_\_

Full Name: \_\_\_\_\_ Gender:  M  F Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Social Security#: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Marital Status:  S  M  D  W # of Children: \_\_\_\_ Work Status:  Full time  Part-time  Retired

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_

Females: Last Menstrual Period: \_\_\_\_\_ Pregnant?  Y  N Nursing?  Y  N

Name of Spouse, Parent or Guardian: \_\_\_\_\_ Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

In case of an Emergency Contact:

\_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

How did you hear about our clinic? Whom may we thank for referring you?

\_\_\_\_\_

**HEALTH CONCERNS: Please list your top health concerns in order of priority.**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

**TREATMENT: What type of treatment are you looking for?**

- I am looking for the most minimal amount of care to “patch up the symptoms” of my problem.
- I am looking to resolve my symptoms and then go on to “fix the cause” of my problem.
- I am looking to take care of my problem and then go on to “achieve optimal health and wellness.”

**COMPLAINT/PROBLEM: In relation to your primary complaint:**

When did you first seek treatment for this problem? \_\_\_\_\_

Has another doctor(s) treated you for this condition: Y N

If yes, whom? \_\_\_\_\_

Treatment(s): \_\_\_\_\_

Have you had any intolerance or reactions to treatments? Y N Describe:

\_\_\_\_\_

If this is a recurrence, when was the first time you noticed this problem?

\_\_\_\_\_

How did it originally occur? \_\_\_\_\_

Has it become worse recently? Y N Same Better Gradually worse

How frequent is the condition? Constant Daily Intermittent Night only

How long does it last? All day Few hours Minutes

Is this condition interfering with your: Work Sleep Daily routine Recreation Other:

\_\_\_\_\_

How long has it been since you really felt good? Days Weeks Months Years  >10 years

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing Other: \_\_\_\_\_

What makes the problem worse? Standing Sitting Lying Bending Lifting Twisting Other: \_\_\_\_\_

Is there anything that you can do to relieve the problem? Y N

If yes, describe: \_\_\_\_\_

If no, what have you tried to do that has not helped?

\_\_\_\_\_

What do you believe is wrong with you?

\_\_\_\_\_

Are there any other conditions or symptoms that may be related to your major symptom? Y N

If yes, what? \_\_\_\_\_

Have you been in a traumatic accident? (i.e. Auto, etc.) Past year Past 5 years Over 5 years Never

Describe:

\_\_\_\_\_

**FRACTURES/SCARS/SURGICAL PROCEDURES: List all scars and surgical procedures you have had.**

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**Please check all of the symptoms that apply**

**(P=Past / C=Current)**

**P / C**

- Headache
- Facial Pain
- Eye Pain
- Blurred Vision
- Dizziness
- Earache
- Forgetfulness
- Confusion
- Sinusitis
- Teeth Grinding
- Dry Mouth
- Excessive Thirst
- Unpleasant Taste
- Neck Pain
- Sore Throat
- Lump in Throat
- Swallowing Pain
- Knee Pain
- Persistent Coughing
- Joint Stiffness
- Rapid Heart Rate

**P / C**

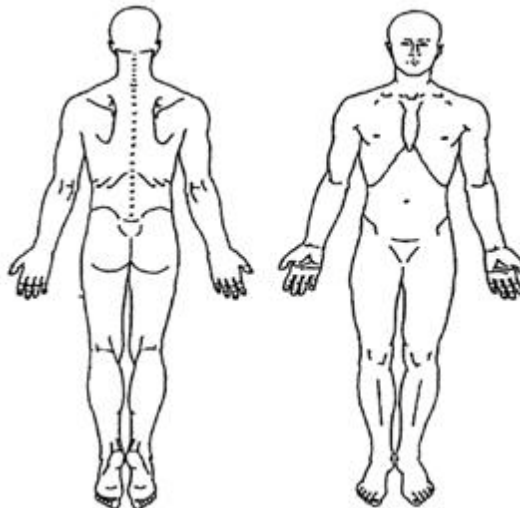
- High Blood Pressure
- Low Blood Pressure
- Abdominal Pains
- Nausea/Vomiting
- Poor Appetite
- Fullness of Bladder
- Urination Difficulty
- Frequent Urination
- Constipation
- Hemorrhoids
- Decreased Sex Drive
- Menstrual Irregularities
- Elbow / Hand Pain
- Tingling in Hands
- Clammy Hands
- Low Back Pain
- Hip Pain
- Shoulder Pain
- Swollen Joints
- Slow Heart Rate
- Ankle / Foot Pain

**P / C**

- Tingling in Feet
- Walking Problems
- Sore Muscles
- Weak Muscles
- Paralysis
- Shakiness
- Sweating
- Insomnia
- Fainting
- Convulsions
- Irritability
- Impatience
- Fatigue
- Feel Loss of Control
- Other: \_\_\_\_\_
- \_\_\_\_\_
- Unsteady Voice
- Poor Circulation
- Chest Pressure
- Swollen Ankles

**Please use the legend symbols below to accurately mark the areas in which you feel these sensations.**

- Stabbing/Cutting - |||    Tingling - :::
- Burning - XXX    Cramping - ^^
- Numbness - ===    Dull - ###



**ALLERGIES: Please check and list all allergies.**

Food: \_\_\_\_\_

Medications: \_\_\_\_\_

Seasonal / Other: \_\_\_\_\_

**DIET:**       Excellent     Good     Fair     Poor

**SUPPLEMENTS:** Do you take Vitamins / Supplements or Herbs?  Y  N

If yes, who recommended them? \_\_\_\_\_  
Please List:

**MEDICATIONS:** Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
<input type="checkbox"/>	Antacids	
<input type="checkbox"/>	Antibiotics	
<input type="checkbox"/>	Antidepressants	
<input type="checkbox"/>	Anti-Diabetics	
<input type="checkbox"/>	Anti-Inflammatory	
<input type="checkbox"/>	Blood Pressure Lowering Meds.	
<input type="checkbox"/>	Cholesterol Lowering Meds.	
<input type="checkbox"/>	Hormone Replacements (HRT)	
<input type="checkbox"/>	Oral Contraceptives	
<input type="checkbox"/>	Other	

**HABITS:**

	Heavy	Moderate	Light	None		5-7x/wk	3-5x/wk	1-3x/wk	None	Type / Freq
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5hrs
Soda / Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		5+	4	3	2	<2
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meals/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		128+ oz	64-128 oz	32-64 oz	16-32 oz	<8 oz
					Water/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WORK ACTIVITY:**  Heavy Labor  Light Labor  Mostly Sitting  Mostly Standing  Walking / Moving  Driving

**FAMILY HISTORY:** Identify any conditions that you, or any of your family members have now or have had in the past: (**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)

- |                          |                   |                     |                  |
|--------------------------|-------------------|---------------------|------------------|
| ___ Alcoholism           | ___ Eczema        | ___ Miscarriage(s)  | ___ Tumor(s)     |
| ___ Anemia               | ___ Emphysema     | ___ Mumps           | ___ Ulcer(s)     |
| ___ Cancer               | ___ Epilepsy      | ___ Pleurisy        | ___ Other: _____ |
| ___ Cold sores           | ___ Goiter        | ___ Pneumonia       | _____            |
| ___ Deep vein thrombosis | ___ Gout          | ___ Polio           | _____            |
| ___ Detached retina      | ___ Heart disease | ___ Rheumatic fever |                  |
| ___ Diabetes             | ___ HIV / AIDS    | ___ Stroke          |                  |

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

Marysville Chiropractic Wellness Center  
Joseph Pilsl, D.C., C.K.T.P.  
104 S. 11<sup>th</sup> - Marysville, KS 66508  
785-562-2326

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DISCLOSURE AND CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

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To the patient: you have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involve. This is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedures.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy, such as those listed below, and other diagnostic testing on me (or the patient named below, for whom I am legally responsible) by Dr Joseph Pilsl, D.C. and / or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

- |  |   |
|--|---|
| -Eyelights / color therapy                                 | -Heavy metals and other toxins detoxification therapy   |
| -Cold laser / light therapy / LLLT                         | -Smoking cessation therapy and / or weight loss therapy |
| -Fascia / percussion therapy                               | -Muscle weakness or neurological inhibition response    |
| -Acupuncture / meridian therapy                            | -Muscle response testing for nutritional deficiencies   |
| -Allergy / Sensitivity Reprogram therapy                   | -Nutritional recommendations / therapy                  |
| -Ion exchange detoxification - EB Pro <sup>®</sup> therapy | -KinesioTaping <sup>®</sup> methods / tape therapy      |

The above named procedures may or may not be considered investigational or experimental by the State of Kansas at this time. By signing this form I acknowledge that I desire to have these procedures performed at this time and in the future as my treatment of choice. I also acknowledge that none of the above procedures are diagnostic in nature and are not to be considered a diagnosis for any ailment, but rather a therapeutic recommendation and alternative –adjunctive wellness treatment only. I also understand that the procedures may or may not be covered by my insurance, and that I may be solely responsible for any charges incurred for these treatments.

If at any time, I decide to decline these treatments, I will do so in writing in advance of the treatments and present the written document of decline of these specific treatments to Marysville Chiropractic Wellness Center, or Dr Joseph Pilsl, D.C. I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guaranties or assurances have been made to me concernign the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent to cover the entire course of treatment for presnet condition and for any future condition(s) for which I seek treatment.

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To be completed by the patient, or patient's representative, if necessary, e.g., if the patient is a minor or physically or legally incapacitated:

Print Name: \_\_\_\_\_

Relationship/Authority to patient: \_\_\_\_\_

Signature of Patient or

Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations**

As a condition of providing treatment to you, Marysville Chiropractic Wellness Center must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of Marysville Chiropractic Wellness Center.

You may revoke this consent at any time by notifying Marysville Chiropractic Wellness Center in writing, except to the extent office has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment, or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information (“Privacy Notice”) for a more complete description of the uses and disclosures that office/staff may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

Marysville Chiropractic Wellness Center has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revise notice by requesting the Privacy Notice in writing or by requesting the notice in person.

You have the right to request Marysville Chiropractic Wellness Center to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. Marysville Chiropractic Wellness Center is required, however, to agree to such requested restrictions. If, however, Marysville Chiropractic Wellness Center agrees to the requested restrictions, Marysville Chiropractic Wellness Center will honor the request and it will be binding on Marysville Chiropractic Wellness Center.

I hereby consent to the use and disclosure by Marysville Chiropractic Wellness Center, its work force, and its business associates of my protected health information for purposes of treatment, payment, and healthcare operations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Personal Representative of patient

\_\_\_\_\_  
Description of Representative’s Authority to Act for Patient

\_\_\_\_\_  
Date