Welcome to Garcia Chiropractic

In order to serve you best we would like to know more about you and your health history.
Please print clearly and fill this out completely prior to your appointment time.

Patient Information

Date: _____ Male/Female (circle one)

Name:_____

Preferred Name:_____

Address:_____

City:_____

State:_____Zip:_____

Birth date: _____ Age:_____

Marital Status: Single Married Widowed Divorced

Social Security # _____

Occupation: _____

Employer: _____

Patient Family Information

Spouse Name: _____

Spouse Employer:_____

Children:

Name:_____ Age: ____

Name:_____ Age: ____

Name:_____ Age: ____

Name:_____ Age: ____

Contact Information

Home Phone: _____

Work Phone:_____

Cell Phone:_____

Email: _____@_____

Insurance

We will be happy to verify your insurance benefits and find out if you have any chiropractic coverage. However, we do collect payment in full for services rendered on the 1st visit.

Do you have insurance you would like to submit?
Yes No

I hereby authorized the doctor to release all information regarding my records if needed.
Initials ____

I understand that I am financially responsible for all charges.
Initials_____

Whom May We Thank for Referring You?

_____

Health History

Have you ever seen a chiropractor before?_____ Approximate last adjustment date:_____

Names of other doctors who have cared for you:_____

Last date of Spinal Examination, X-ray, MRI, CT, or Bone Scan:_____

Were you injured in traffic related incident or on commercial property in the past year? Yes No
If yes what day/time?_____

Were you injured at work in the past year? Yes No
If yes what day/time?_____

Primary cause for todays visit?_____

Is your condition: getting worse, staying the same or improving (circle one)

Does it interfere with: Work Sleep Daily Routine Recreation

Review of Systems

Please circle any of the conditions you have suffered from in the **last 6 months**.

Constitution: Fatigue	Weight Loss	Loss of Appetite	Night Sweats	Fever
Eyes: Blurred Vision	Double Vision	Loss of Vision		
ENT: Sinus Issues	Nosebleeds	Hearing Loss	Ringing in Ears	Sore Throat
Facial Pain	Facial Numbness			
Cardiovascular:	Chest Pain	Palpitations	Swelling in Legs	Swelling in Feet
Respiratory:	Shortness of Breath	Coughing up Blood	Wheezing	
Gastrointestinal:	Heartburn	Constipation	Abdominal Pain	Incontinence
Nausea				
Genito-Urinary:	Painful Urination	Frequent Urination	Bladder Problems	Incontinence
Skin: Itching	Breast Changes	Persistent Rashes	Hair Loss	Increased *Hair*
Neurological:	Headaches	Migraines	Problems with Balance	Dizziness
Tremors	Loss of Consciousness			
Psychiatric:	Depression	Anxiety		

Other:_____

Medications and Supplements you are taking:

_____

Do you smoke/Vape?_____ amount/Day_____ Drink Alcohol?_____ Drinks/Week_____

Drink Coffee/Caffeine? _____ Cups/Day_____ High Stress Level (physical, mental, spiritual)? _____

Reason:_____

Recreational Activities you participate in: _____

Recreational Activities as a child: _____

For Women Only: Are you pregnant? Yes No Due Date:_____

I certify that to the best of my knowledge I am not pregnant, and the doctors and staff of Garcia Chiropractic have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Initial _____ Date_____

Trauma History

Please give us a brief description of any of these events you can think of and the dates.

Description Date

Minor/Major Auto Accidents (Even if you were not driving)

_____ _____

_____ _____

Falls/ Strains (Slip and falls, sports injuries, lifting injuries, etc.)

_____ _____

_____ _____

Head Injuries/Loss of Consciousness (Even as a child)

_____ _____

_____ _____

Trauma history continued

Description Date

Broken Bones/Dislocations

_____ _____

_____ _____

_____ _____

Surgeries

_____ _____

_____ _____

_____ _____

Hospitalizations

_____ _____

_____ _____

_____ _____

Family History (Diabetes, Cancer, Heart Attack/Stroke) *Example Below*

Maternal/Paternal Relative: Maternal Grandpa *Disease/Condition: Diabetes/Heart attack* *Age/Status (alive/deceased): 82, deceased*

_____ _____ _____

_____ _____ _____

_____ _____ _____

I hereby authorize the doctor, and/or his associates to examine me, and to perform any necessary diagnostic procedures, including x-ray to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Topics covered are Uses and Disclosure, Your Rights, Our Duties, Complaints & Contact Information. A complete copy of this document is available upon request.

Patient Signature_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)

- I give permission for my name to be recorded as a means for me to be called to my adjustment.
- I give permission to use my name in the office if I refer a new member to the practice.
- I give permission for my image to be posted on the @garciachiropractic Instagram/Facebook company page
- If I choose to give a testimonial of my experiences while under care, I give permission for certain information about my case to be disclosed for office purposes.

Patient Signature_____ **Date**_____

(If patient is under 18, Signature of Legal Guardian)

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____Signature: _____ Date:_____

Parent or Guardian: _____Signature: _____ Date:_____

Witness Name: _____Signature: _____Date:_____