

Dr. Mike Snyder, D.C.

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NEW PATIENT INFORMATION

Name _____ Today's date _____

Date of birth _____ / _____ / _____ Age _____ Height (ft / in) _____ Weight (lbs) _____

Marital status: ☐ M ☐ S ☐ W ☐ D How many children _____

Cell phone _____ Home phone _____ Email _____

Address _____ City _____ Zip _____

Occupation _____ Employer _____ Work phone _____

Spouse's name _____ Occupation _____ Employer _____

Emergency contact _____ Phone _____

Whom may we thank for referring you? (How did you hear about us?) _____

HEALTH HISTORY

Chiropractors you have seen before:

Name _____ When _____

Name _____ When _____

Primary care doctor _____

Date of last physical exam _____

X-rays (when and body region) _____

MRI (when and body region) _____

Surgeries (type and when) _____

Past accidents or injuries:

Type _____ When _____ Hospitalized? ☐ Y ☐ N

Type _____ When _____ Hospitalized? ☐ Y ☐ N

Medications, vitamins and supplements you take:

Type _____ For _____ How long _____

Type _____ For _____ How long _____

Type _____ For _____ How long _____

Type _____ For _____ How long _____

CURRENT COMPLAINTS

1 • PRIMARY COMPLAINT

Describe it _____ Started ____ / ____ / ____

Pain over the last 24 hours (circle a range):

0 1 2 3 4 5 6 7 8 9 10

Time with pain (circle): 0% 25% 50% 75% 100%

Side (circle): R / L / BOTH / CENTER

Type: ☐ Sharp/stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness

Does it travel? ☐ Y ☐ N If yes, draw an arrow on the figure

What makes it better? _____ Worse? _____

2 • SECONDARY COMPLAINT • IF ANY

Describe it _____ Started ____ / ____ / ____

Pain over the last 24 hours (circle a range):

0 1 2 3 4 5 6 7 8 9 10

Time with pain (circle): 0% 25% 50% 75% 100%

Side (circle): R / L / BOTH / CENTER

Type: ☐ Sharp/stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness

Does it travel? ☐ Y ☐ N If yes, draw an arrow on the figure

What makes it better? _____ Worse? _____

3 • TERTIARY COMPLAINT • IF ANY

Describe it _____ Started ____ / ____ / ____

Pain over the last 24 hours (circle a range):

0 1 2 3 4 5 6 7 8 9 10

Time with pain (circle): 0% 25% 50% 75% 100%

Side (circle): R / L / BOTH / CENTER

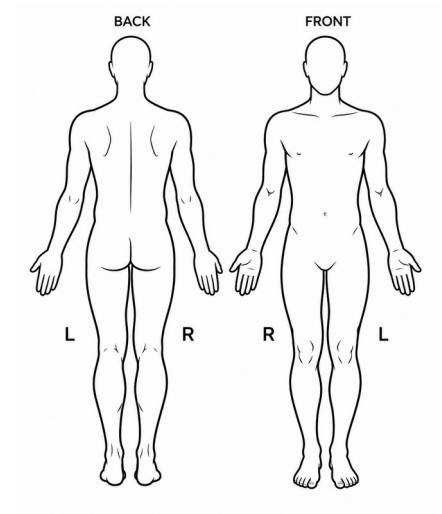
Type: ☐ Sharp/stabbing ☐ Burning ☐ Dull ☐ Tingling ☐ Numbness

Does it travel? ☐ Y ☐ N If yes, draw an arrow on the figure

What makes it better? _____ Worse? _____

MARK YOUR PAIN

Circle each painful area on the figures and number it 1, 2 or 3 to match the complaints at left.



ACTIVITIES AFFECTED BY YOUR CONDITION

Check anything your condition affects or that makes it worse.

- ☐ Work activities
- ☐ Sleep
- ☐ Walking
- ☐ Static sitting
- ☐ Static standing
- ☐ Bending
- ☐ Lifting items
- ☐ Carrying items
- ☐ Driving
- ☐ Computer use
- ☐ Exercising
- ☐ Household chores
- ☐ Getting out of bed
- ☐ Taking a deep breath
- ☐ Coughing
- ☐ Sneezing
- ☐ Bearing down/bowel movements
- Other _____

Was this from an auto accident? ☐ Y ☐ N A work injury? ☐ Y ☐ N

If yes, explain _____ Date of accident _____

Other doctors seen for these problems? ☐ Y ☐ N Who _____

HEALTH CHECKLIST

Check anything you have had in the past or have now.

	PAST	NOW		PAST	NOW		PAST	NOW
Neck pain	☐	☐	Convulsions	☐	☐	Diabetes	☐	☐
Shoulder pain R / L	☐	☐	Insomnia	☐	☐	Cancer	☐	☐
Upper back pain	☐	☐	Depression	☐	☐	Arthritis	☐	☐
Low back pain	☐	☐	Tinnitus (ear noises)	☐	☐	Asthma or emphysema	☐	☐
Knee pain R / L	☐	☐	Impaired vision	☐	☐	Ulcer	☐	☐
Jaw pain R / L	☐	☐	Rapid heart beat	☐	☐	Kidney stones	☐	☐
Swelling or stiff joints	☐	☐	Chest pains	☐	☐	Bladder infection	☐	☐
Headaches	☐	☐	High blood pressure	☐	☐	Allergies	☐	☐
Dizziness	☐	☐	Heart attack	☐	☐	Drug/alcohol dependency	☐	☐
Fainting	☐	☐	Stroke	☐	☐	HIV positive / AIDS	☐	☐
Indigestion/heartburn	☐	☐						

Do you use: ☐ Tobacco ☐ Alcohol ☐ Tranquilizers/sedatives ☐ Painkillers/pain medication _____

LIFESTYLE

Hours of sleep per night _____ Sleep position: ☐ Side ☐ Stomach ☐ Back Age of mattress _____

Hours per day at a computer _____ Does sitting at the computer bother your condition? ☐ Y ☐ N

Do you watch TV in bed? ☐ Y ☐ N On the couch? ☐ Y ☐ N Position _____

Do you use a laptop? ☐ Y ☐ N Where _____

Do you wear: ☐ Arch supports ☐ Heel lifts ☐ Inserts ☐ Orthotics ☐ Braces or supports

Do you: ☐ Run ☐ Bike ☐ Swim ☐ Work out ☐ Yoga Other sports _____

How much and how often do you exercise _____

Is your current condition interfering with exercise? ☐ Y ☐ N How _____

PAYMENT POLICY

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that payment for services rendered is due at the time of service unless other arrangements are made.

PATIENT SIGNATURE

DATE

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE

DATE

INFORMATION TAKEN BY

DATE

Dr. Mike Snyder, D.C.

Notice of Privacy Practices

Consent for Use and/or Disclosure of Protected Health Information

To carry out treatment, payment and/or health care operations

Through the use of this consent form, Michael J. Snyder, D.C. is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.
2. We will only disclose protected health information with your express written authorization.
3. A notice containing the office's privacy practices, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.
4. This office reserves the right to change its privacy practices that are described in the above referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.
5. You have the right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment, payment and/or health operations.
6. You have the right to inspect your records and amend or correct health information.
7. If this office agrees to a requested restriction, it will take approximately 30 days to do so.
8. You have the right to revoke this consent, in writing, at any time, for all future transactions, with the understanding that such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.
9. Should you revoke this consent at any time, the office retains its right to refuse treatment based on the revocation and future lack of such consent.
10. You will sign and date all consents requested to which you agree.
11. I hereby authorize Michael J. Snyder, D.C. to use and/or disclose health information for the purpose of filing your insurance claims, consulting with other health providers and for billing purposes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

NAME OF INDIVIDUAL (PRINTED)

SIGNATURE OF INDIVIDUAL

SIGNATURE OF LEGAL REPRESENTATIVE
Attorney-in-fact, guardian, or parent if minor

RELATIONSHIP

DATE SIGNED

Dr. Mike Snyder, D.C.

PATIENT CONSENT

Informed Consent to Chiropractic Adjustments and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and I am informed that, as in the practice of medicine and chiropractic, there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. 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 judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, is in my best interest.

I have read, and/or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

PRINT PATIENT'S NAME

SIGNATURE OF PATIENT

DATE SIGNED

Dr. Mike Snyder, D.C.

PATIENT CONSENT

Consent for Text Messaging

I consent to receive text messages from Dr. Mike Snyder, D.C. As part of this consent, you represent and warrant the following: (1) Dr. Mike Snyder, D.C., or others acting on his behalf, may send text messages in various formats and with various contents, including but not limited to text messages about appointment reminders. (2) You are the owner or authorized user of the mobile phone number identified below. You will notify us if you are no longer the owner or authorized user of the mobile phone number identified below. (3) You are solely responsible for any message and data charges associated with such text messages.

If you do not wish to receive text messages from Dr. Mike Snyder, D.C., or others acting on his behalf, you should not sign this form.

MOBILE PHONE NUMBER

PRINT NAME

SIGNATURE

DATE