Confidential New Patient Forms
Please print clearly.

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Last Name | First Name | Middle Name or Initial

Address | City | State | Zip Code

Home Phone | Cell Phone | Email

Appointment reminder ◯ Phone ◯ Email ◯ Text ◯ **Verizon** ◯ **At&t** ◯ **Sprint** ◯ **T Mobile** ◯ **Cricket** ◯ **Other**

Gender ◯ Male ◯ Female | Age | Birthdate (MM/DD/YYYY) | Social Security Number

Race

◯ American Indian ◯ Alaskan Native ◯ Asian
◯ Native Hawaiian ◯ Other Pacific Islander ◯ Other
◯ Decline to answer ◯ Black/African American ◯ White

Ethnicity

◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Decline to answer

Preferred Language

Marital Status

◯ Married ◯ Divorced
◯ Single ◯ Separated
◯ Widowed
◯ Minor

Employment

◯ Part time ◯ Full time ◯ Retired
◯ None ◯ Self

Employer

Employer Phone

May we contact you at work? ◯ Yes ◯ No

Spouse's Name | Do you have children? ◯ Yes ◯ No How many?

Emergency Contact | Emergency Contact's Phone | Primary Physician

Have you consulted a chiropractor before? ◯ Yes ◯ No

If so, whom?

When?

Current Medications with dosage

1 mg
2 mg
3 mg
4 mg
5 mg

Current Allergies(including medications):

inches — Current Height

pounds — Current Weight

/ — Current blood pressure (if known)

Smoking Status (age 13 or over)

◯ Never a smoker ◯ Former Smoker
◯ Current every day smoker ◯ Current someday Smoker
◯ Heavy Smoker ◯ Light Smoker

Stopped smoking _____ months/years ago

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Please describe your complaints below. **Use the secondary and additional complaint areas if applicable.**

Primary Complaint

The primary reason that I am seeking care today is:

And are the result of (mark circle):

◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did your symptoms begin?)

Prior interventions

(What have you done to relieve the symptoms?)

◯ Prescription Medication ◯ Acupuncture

◯ Over the counter drugs ◯ Chiropractic

◯ Homeopathic remedies ◯ Massage

◯ Physical Therapy ◯ Ice

◯ Surgery ◯ Heat

◯ Other _____

Using the visual analog pain scale, circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

no pain Moderate pain Worst pain possible

Your current pain is:

◯ Dull ◯ Sharp ◯ Ache ◯ Throbbing

◯ Stabbing ◯ Shooting ◯ Burning ◯ Numbness

◯ Tingling ◯ Soreness ◯ Stiffness ◯ Cramping

How often are you having pain?

◯ Constant ◯ Frequent ◯ Intermittent ◯ Occasional

Secondary Complaint

The secondary reason that I am seeking care today is:

And are the result of (mark circle):

◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did your symptoms begin?)

Prior interventions

(What have you done to relieve the symptoms?)

◯ Prescription Medication ◯ Acupuncture

◯ Over the counter drugs ◯ Chiropractic

◯ Homeopathic remedies ◯ Massage

◯ Physical Therapy ◯ Ice

◯ Surgery ◯ Heat

◯ Other _____

Using the visual analog pain scale, circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

no pain Moderate pain Worst pain possible

Your current pain is:

◯ Dull ◯ Sharp ◯ Ache ◯ Throbbing

◯ Stabbing ◯ Shooting ◯ Burning ◯ Numbness

◯ Tingling ◯ Soreness ◯ Stiffness ◯ Cramping

How often are you having pain?

◯ Constant ◯ Frequent ◯ Intermittent ◯ Occasional

What else should Dr. Wiley or Dr. Lanes know about your current condition? _____

How does your current condition interfere with your:

Work/Career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

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Please describe your complaints below. **Use the secondary and additional complaint areas if applicable.**

Additional Complaint

The additional reason that I am seeking care today is:

And are the result of (mark circle):

◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did your symptoms begin?)

Prior interventions

(What have you done to relieve the symptoms?)

◯ Prescription Medication ◯ Acupuncture

◯ Over the counter drugs ◯ Chiropractic

◯ Homeopathic remedies ◯ Massage

◯ Physical Therapy ◯ Ice

◯ Surgery ◯ Heat

◯ Other _____

Using the visual analog pain scale, circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

no pain Moderate pain Worst pain possible

Your current pain is:

◯ Dull ◯ Sharp ◯ Ache ◯ Throbbing

◯ Stabbing ◯ Shooting ◯ Burning ◯ Numbness

◯ Tingling ◯ Soreness ◯ Stiffness ◯ Cramping

How often are you having pain?

◯ Constant ◯ Frequent ◯ Intermittent ◯ Occasional

Additional Complaint

The additional reason that I am seeking care today is:

And are the result of (mark circle):

◯ An accident or injury

◯ Work ◯ Auto ◯ Other _____

◯ A worsening long-term problem

◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did your symptoms begin?)

Prior interventions

(What have you done to relieve the symptoms?)

◯ Prescription Medication ◯ Acupuncture

◯ Over the counter drugs ◯ Chiropractic

◯ Homeopathic remedies ◯ Massage

◯ Physical Therapy ◯ Ice

◯ Surgery ◯ Heat

◯ Other _____

Using the visual analog pain scale, circle your pain level:

0 1 2 3 4 5 6 7 8 9 10

no pain Moderate pain Worst pain possible

Your current pain is:

◯ Dull ◯ Sharp ◯ Ache ◯ Throbbing

◯ Stabbing ◯ Shooting ◯ Burning ◯ Numbness

◯ Tingling ◯ Soreness ◯ Stiffness ◯ Cramping

How often are you having pain?

◯ Constant ◯ Frequent ◯ Intermittent ◯ Occasional

What else should **Dr. Wiley or Dr. Lanes** know about your additional condition? _____

How does your additional condition interfere with your:

Work/Career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

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Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body.
Please select the circle beside any condition that you've **HAD** or currently **HAVE** and initial to the right.

Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	TMJ issues	
◯	◯	Knee Injuries	◯	◯	Foot/Ankle Pain	◯	◯	Shoulder pain	◯	◯	Hip disorders	Initials
◯	◯	Back Problems	◯	◯	Elbow/Wrist Pain	◯	◯	Neck pain	◯	◯	Poor posture	

Neurological

Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Pins and needles	◯	◯	Numbness	
◯	◯	Headache	◯	◯	Dizziness							Initials

Cardiovascular

Had	Have		Had	Have		Had	Have		None ◯
◯	◯	High blood pressure	◯	◯	High cholesterol	◯	◯	Angina	
◯	◯	Low blood pressure	◯	◯	Poor circulation	◯	◯	Excessive bruising	Initials

Respiratory

Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Asthma	◯	◯	Emphysemia	◯	◯	Shortness of breath	
◯	◯	Apnea	◯	◯	Hay fever	◯	◯	Pneumonia	Initials

Digestive

Had	Have		Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Anorexia	◯	◯	Ulcer	◯	◯	Heartburn	◯	◯	Diarrhea	
◯	◯	Bulimia	◯	◯	Food sensitivites	◯	◯	Constipation	◯	◯	Belching	Initials

Sensory

Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Blurred Vision	◯	◯	Hearing loss	◯	◯	Loss of smell	
◯	◯	Ringing in ears	◯	◯	Chronic ear infection	◯	◯	Loss of taste	Initials

Endocrine

Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Thyroid issues	◯	◯	Hypoglycemia	◯	◯	Swollen glands	
◯	◯	Immune disorder	◯	◯	Frequent infection	◯	◯	Low energy	Initials

Genitourinary

Had	Have		Had	Have		Had	Have		None ◯
◯	◯	Kidney stones	◯	◯	Bedwetting	◯	◯	Erectile dysfunction	
◯	◯	Infertility	◯	◯	Prostate issues	◯	◯	PMS symptoms	Initials

Constitutional

Had	Have		Had	Have		Had	Have			None ◯
◯	◯	Fainting	◯	◯	Poor appetite	◯	◯	Fatigue	◯	◯	Sudden weight loss or gain	circle one	Initials

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Past history, Personal, Family and Social

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Illnesses

Check the illnesses you have **HAD** in the past and **HAVE** now.

Had	Have		Had	Have	
◯	◯	AIDS	◯	◯	Tuberculosis
◯	◯	Alcholism	◯	◯	Typhoid fever
◯	◯	Allergies	◯	◯	Ulcer
◯	◯	Arteriosclerosis	◯	◯	Other: _____
◯	◯	Cancer			
◯	◯	Chicken pox			
◯	◯	Diabetes			
◯	◯	Epilepsy			
◯	◯	Glaucoma			
◯	◯	Goiter			
◯	◯	Gout			
◯	◯	Heart disease			
◯	◯	Hepatitis			
◯	◯	HIV positive			
◯	◯	Malaria			
◯	◯	Measles			
◯	◯	Multiple Sclerosis			
◯	◯	Mumps			
◯	◯	Polio			
◯	◯	Rheumatic fever			
◯	◯	Scarlet fever			
◯	◯	Sexually transmitted disease			
◯	◯	Stroke			

Injuries:

- ◯ Had a fractured or broken bone
- ◯ Had a spine or nerve disorder
- ◯ Been knocked unconscious
- ◯ Been injured in an accident
- ◯ Used neck or back bracing
- ◯ Used a crutch or other support
- ◯ Received a tatoo
- ◯ Hand a body piercing

Operations

Surgical interventions, which may or may not have included hospitalization.

- ◯ Appendix removal
- ◯ Bypass surgery
- ◯ Cancer
- ◯ Cosmetic surgery
- ◯ Elective surgery:_____
- ◯ Eye surgery
- ◯ Hysterectomy
- ◯ Pacemaker
- ◯ Spine: _____
- ◯ Tonsillectomy
- ◯ Vasectomy
- ◯ Other: _____

Treatments: Check the ones you have received in the PAST or receiving CURRENTLY.

Past	Currently		Past	Currently	
◯	◯	Acupuncture	◯	◯	Inhaler
◯	◯	Antibiotics	◯	◯	Massage therapy
◯	◯	Birth control pills	◯	◯	Physical therapy
◯	◯	Blood transfusions	◯	◯	Dialysis
◯	◯	Chemotherapy	◯	◯	Homeopathy
◯	◯	Chiropractic Care	◯	◯	Herbs
◯	◯	Hormone replacement	◯	◯	Medications
◯	◯	Other_____			

Family History

Some health issues are hereditary. Tell Dr. Wiley or Dr. Lanes about the health of your immediate familly members.

Relative	**Age (if living)**	**State of health**				**Cause of death**	
		Good	Poor	Illnesses	Age of death	Natural	Illnesses
Mother	_____	◯	◯	_____	_____	◯	◯
Father	_____	◯	◯	_____	_____	◯	◯
Sister 1	_____	◯	◯	_____	_____	◯	◯
Brother 1	_____	◯	◯	_____	_____	◯	◯
Other	_____	◯	◯	_____	_____	◯	◯

Are there any other hereditary health issues that you know about? _____

Social History: Tell Dr. Wiley or Dr. Lanes about your health habits and stress levels.

Alcohol use ◯ Daily ◯ Weekly How much?_____
Coffee use ◯ Daily ◯ Weekly How much?_____
Tobacco use ◯ Daily ◯ Weekly How much?_____
Exercising ◯ Daily ◯ Weekly How much?_____
Pain relievers ◯ Daily ◯ Weekly How much?_____
Soft Drinks ◯ Daily ◯ Weekly How much?_____
Water Intake ◯ Daily ◯ Weekly How much?_____

Prayer/Meditation? ◯ Yes ◯ No
Job pressure/stress? ◯ Yes ◯ No
Financial peace? ◯ Yes ◯ No
Vaccinated? _____
Mercury fillings? _____
Recreational drugs? _____

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Activites of Daily Living

How does this condition currently interfere with your lifte and ability to function?

	No effect	Mild effect	Moderate effect	Severe effect		No effect	Mild effect	Moderate effect	Severe effect
Grocery shopping	◯	◯	◯	◯	Sitting	◯	◯	◯	◯
Getting out of a chair	◯	◯	◯	◯	Standing	◯	◯	◯	◯
Household chores	◯	◯	◯	◯	Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯	Walking	◯	◯	◯	◯
Showering/bathing	◯	◯	◯	◯	Lying down	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯	Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯	Love life	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯	Falling asleep	◯	◯	◯	◯
Getting in/out of the car	◯	◯	◯	◯	Staying asleep	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯	Concentrating	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯	Exercising	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯	Yard work	◯	◯	◯	◯

What is the major stressor in your life? _____

How much sleep do you average per night? _____ Hours _____

What is your preferred sleeping position?

What is the approximate age and type of your pillow and mattress? _____

Describe your typical eating habits:

◯ Skip breakfast ◯ Two meals a day ◯ Three meals a day ◯ Snacking between meals

What would be the most significant thing that you could do to improve your health?

_____

In addition to the main reason for your visit today, what additional health goals do you have?

_____

Acknowlegements

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowlege that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Patient (or Guardian's) Signature Date (MM/DD/YYYY)

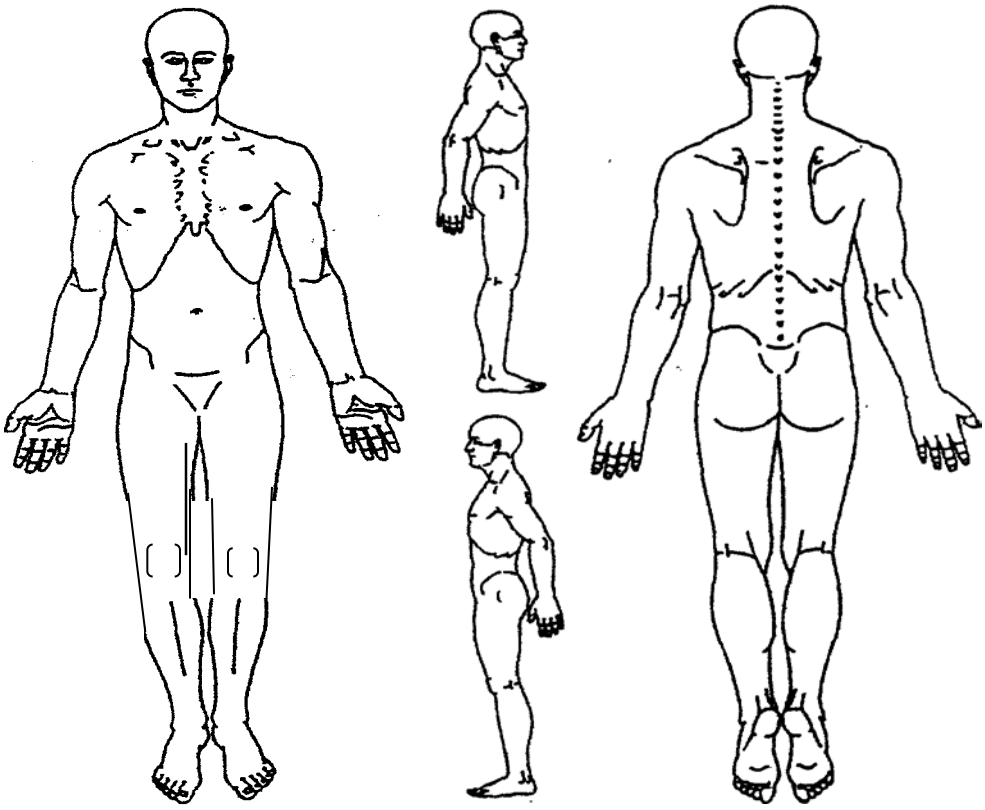
Patient Name_____ Date_____

Dr. James Wiley, DC Dr. Ashlyn Lanes, DC

Mark the areas on this body where you feel pain. Use the appropriate symbols.

KEY:
USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER·



Patient Name: _____ Date: _____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully.

Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1) If you have never been adjusted, or if it has been awhile since your last adjustment you may experience soreness or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2) If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20 minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

3) Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4) Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or Re-injure your condition.

5) Unless indicated by the doctor, you may return to work/school after your appointment.

6) If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at **719-687-6683.**

I have read and understand the instructions given for follow-up care.

Patient/Guardian Signature: _____

Date: _____

Patient Name: _____ Date: _____

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom 1 am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff 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, whether signatories to this form or not.

I have had an 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 procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, 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 then known, and is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient:_____

Name Printed of Guardian/ Parent:_____

Relationship to Patient: Mother Father Guardian Other:_____

Signature of Guardian/ Parent: _____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date: _____

Patient Name: _____ Date: _____

UTE PASS FAMILY CHIROPRACTIC
STATEMENT OF PRIVACY PRACTICES

We are dedicated to protecting the privacy of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act. This includes issues related to your treatment, payment, and our chiropractic care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose, but it will never otherwise be given to anyone including family members without your written consent.

Collecting Protected Health Information

We only request personal information needed to provide our standard of quality chiropractic care, implement payment activities, conduct normal chiropractic practice operations and comply with the law. This may include your name, address, telephone number(s), Social Security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the fullest extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages.

Patient Rights

You have a right to get copies of your healthcare information, and to receive a list of instances in which we or our business associates have disclosed your information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You may also notify the US Department of Human Services.

Thank you for being our patient. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Patient Name: _____

Patient Signature: _____ Date: _____