Patient Name: ____ **Date:** _______________

Address_________________________________**City**________________ **State** __________ **Zip Code** ___________

H. Phone ____________________________**W. Phone**________________ **Cell Phone** __________________________

Email Address: ____________________________________@_____________________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Text / Mail

Gender: M F **Marital Status:** M S D W **Date of Birth**______________ **Age**___________

Social Security #______________________________ **Preferred Language:** ___________________________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasion)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Occupation____

Employer____

Referred by: ____

Have you ever received Chiropractic Care? Yes No If yes, when? _________________________

Name of most recent Chiropractor: ____

1. **Reasons for seeking chiropractic care:**

Primary reason:
____

Secondary reason:
____

2. **Previous interventions, treatments, medications, surgery or care you have sought for your complaint(s):**
____
____
____
____

Patient Name: ____ **Date:** _______________

3. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
□ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
□ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other __________
□ None of the above

B. Previous Injury or Trauma:

____

Have you ever broken any bones? Which?

____

C. Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication	Dosage and Frequency (i.e. 5mg once a day, etc.)

D. Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

E. Surgeries:

Date	Type of Surgery

Dr. Shaun E. Rinow
100 Biddle Avenue, Suite 102
Newark, DE 19702

mynewarkchiro.com
Phone: 302-595-2344
Fax: 302-595-2134

Patient Name: ____ **Date:** _______________

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

____
____
____
____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _______________ □ None of the above

Deaths in immediate family: ____

Cause of parents or siblings death Age at death

____
____
____

Social and Occupational History:

A. Job description:

____

B. Work schedule:

____

C. Recreational activities:

____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

____
____

E. Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Patient Name: ____ **Date:** _______________

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ____________ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other ___________ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _______________ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other ________________ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other ______________________ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _________ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _______________ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other __________ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other ______________________ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other ____________ □ None of the above

Patient Name: ____ **Date:** _______________

Is there anything else in your past medical history that you feel is important to your care here?
____
____
____
____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. Rinow/Integrity Sport & Spine Chiropractic Center for services performed.

Patient or Guardian Signature ________________________________ Date_________________________

☐ **I choose to decline receipt of my clinical summary after every visit**.
(These summaries are often blank as a result of the nature and frequency of chiropractic care).

Patient Name: ____ **Date:** _______________

NEW PATIENT HISTORY FORM

Symptom 1 ____________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 ____________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? ____
- What makes the symptom worse? (circle all that apply):
  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): ______________________________
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
  - If yes, where does the symptom radiate? ____________________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  - Morning Afternoon Evening Night Unaffected by time of day

Patient Name: ____ **Date:** _______________

Assignment of Benefits – Policy of Payment

Assignment of Benefit:

I hereby assign all medical benefits, to include Major Medical benefits to which I am entitled, including Medicare, private insurance, auto (PIP/Med pay) and any other health plans to **Integrity Sport & Spine Chiropractic Center, LLC.**

I agree that all payments are to be payable solely to and sent directly to Dr. Shaun E. Rinow, 100 Biddle Avenue, Suite 102, Newark, DE 19702, regardless of any other agreements or contracts I may enter into with any attorney or any other individual, group or other company subsequent to this date.

Policy of Payment:

We will file your claim forms and assist you in every way we can. However, the contract is between you and your insurance company and you are fully responsible for any account not paid by insurance plan. Our office does **NOT** guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your claim is denied or your policy changes, and changes affect the verification received from your insurance company, you will be responsible for the full amount of your bill. Our office will **NOT** enter into dispute with your insurance company over your claim. This is your responsibility and obligation.

My signature affirms all of the statements made above.

Signature:_________________________________

Printed Name: _____________________________

Date: _______________________

Patient Name: ____ **Date:** _______________

Authorization for the Release of Medical Records

Patient Name:____Date of Birth:____________
(also list maiden name/other names used)

I hereby request and authorize:

Dr. Shaun E. Rinow
Integrity Sport & Spine Chiropractic Center, LLC
100 Biddle Avenue, Suite 102
Newark, DE 19702

Primary Doctor:____

Address:____

City/State/Zip____

Purpose for disclosure:
_____ Treatment, Payment OR _____ Other (Specify)___________________

This authorization will be effective for six months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

____Date:_______________
Signature of Patient

OR
____Date:_______________
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

Patient Name: ____ **Date:** _______________

INFORMED CONSENT

PATIENT NAME ____

Dr. Shaun E. Rinow
Integrity Sport & Spine Chiropractic Center
100 Biddle Avenue
Suite 102
Newark, DE 19702
302-595-2344

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a chiropractic adjustment. As the joints in your spine are moved, you may hear a "pop" as part of the process.

There are certain complications that can occur as a result of a chiropractic adjustment. These compilations include, but are not limited to: muscle strain, fractures, costovertebral strains and separation. Extremely rare complications include, but are not limited to stroke. The most common complication or complaint following a chiropractic adjustment is an ache or stiffness at the site of adjustment.

I am aware of these extremely rare complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, please let us know while taking your clinical history.

DATE ___________________________________

____
Printed Name

____
Signature

____
Signature of Parent/Guardian (if patient is a minor)