George Siegfried, D.C.
Chiropractic Physician
Since 1983
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Welcome to the Clinic!

Thank you for taking time to fill this out. It will reduce your wait at the clinic.

New Patient Consultation Form

Filled out by:______________________________ Date: __________________________

Name: ____ **DOB**: ________________**Age**:__________
Home Address: ______________________________**City:**______________ **State**: _____**Zip**:__________
Mailing Address: _____________________________**City:**______________ **State**: _____**Zip**:__________
Cell#: ______________________ **Work#**: ___________________**Occupation**: __________________
Email: ____
(your email is confidential and will NOT be given out)
For Appointment Reminders what is your Preferred Method of Contact? Text ☐ Call ☐ Email ☐
Emergency Contact Name:____________________________ **Phone#** __________________________
Whom may we thank for referring you? ____

What brings you to the clinic today?
☐ Chiropractic Care ☐ Car Accident ☐ Work Injury ☐ Nutrition Consultation
Date of Injury: __________________Your Insurance Carrier/WC Ins: ___________________________
Claim#:___________________________________ Policy#: ____________________________________
MVA Only: At Fault Ins: __________________________ Claim#: _______________________________
Were you or did you: ☐ Hit another car ☐ Ran off the road ☐ Hit a deer ☐ Other: _________________
Was the car insured at the time of the accident? Yes ☐ No ☐ If no, why:_______________________
Were you on the job at the time of the accident? Yes ☐ No ☐ If yes, for who:___________________

Have you been to a chiropractor before? Yes ☐ No ☐ Who? _______________________________
For what condition? ________________________________When? ______________________________
Were you satisfied with your care? Yes ☐ No ☐
What is your main complaint today? ____
Have you lost any workdays? Yes ☐ No ☐ How Many? ___________________________________
My pain/complaint started:____________________**Have you had this pain before?** Yes ☐ No ☐
How does this affect your daily life?____
What makes your pain better & when is it better?____
What makes your pain worse & when is worse? ____

Please Go To Page 2:

Are you taking any medications? Yes ☐ No ☐

If so, for what condition(s)?____

Are you taking any supplements/vitamins? Yes ☐ No ☐

If so for what condition(s)?____

What other doctors or treatment have you seen for your condition? (Medical, Naturopathic, etc.)

____

Were X-rays or MRI's Taken? Yes ☐ No ☐ **When?**____________ **Where?**__________________

Do you use arch supports/orthotics in your shoes? Yes ☐ No ☐

Do you sleep well? Yes ☐ No ☐ Sometimes ☐

Do you have good energy? Yes ☐ No ☐ Sometimes ☐

Do you have a good appetite? Yes ☐ No ☐ Sometimes ☐

Are you under a lot of stress? Yes ☐ No ☐ Sometimes ☐

Do you smoke? Yes ☐ No ☐ Cigarettes? Marijuana? Vape? How often? _____________________

Do you drink alcohol? Yes ☐ No ☐ How often? ____

Do you exercise? Yes ☐ No ☐ What kind? ____

Are you under care for any other conditions? Yes ☐ No ☐ Which ones? ____________________

____

Have you had any surgeries? Yes ☐ No ☐ For what? ______________________________________

____

Any broken bones? Yes ☐ No ☐ Which ones? ____

What kind of water do you drink? ☐ Tap ☐ Bottled ☐ Spring ☐ Distilled ☐ Filtered

Females: Are you currently pregnant? Yes ☐ No ☐ Due Date: ______________________________

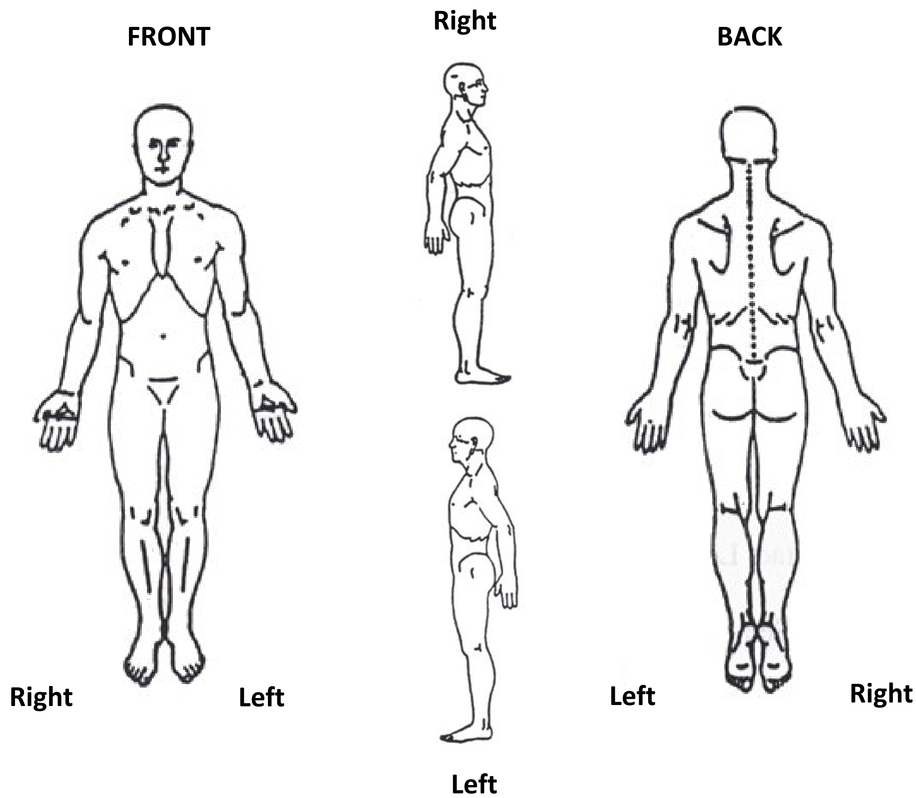
Check the following conditions you have NOW or HAVE HAD:

☐ Arthritis	☐ Cancer	☐ Heart Disease	☐ Back Problems	☐ Ulcers	☐ Stroke
☐ Alcoholism	☐ Constipation	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	
☐ Diarrhea	☐ Convulsions	☐ Emphysema	☐ Epilepsy	☐ Migraines	☐ Menstrual Cramps
☐ Diabetes	☐ Goiter	☐ Nervousness	☐ Heart Attack	☐ Scoliosis	☐ Thyroid Problems
☐ Gout	☐ Miscarriage	☐ Neuritis	☐ Depression	☐ Cold sores	☐ Irregular Periods
☐ Pleurisy	☐ Pneumonia	☐ Gall Bladder	☐ Whooping Cough	☐ High Blood Pressure	

If you are in pain <u>NOW</u>, how bad is it?
Please circle the appropriate number on this scale.

Use the letters to the right to indicate the type and location of the pain.

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)



A = Aching

B = Burning

N = Numbness

S = Stabbing

T = Tingling

W = Weakness

O = Other

What is your health goal for your complaint?

_____ Patch care = pain relief
_____ Fix Care = trying to get your body as near to normal as possible.

***Any other comments that may help us improve you care? We are here to help you.**

____
____
____
____

Please Go To Page 4:

OFFICE POLICIES: The information on this application is accurate to the best of my knowledge. If I am accepted as a patient at the clinic, I understand that this is a cash clinic and that Dr. Siegfried is out-of-network for all private insurances except for work and car accident injuries. Meaning that payment is due at the time of service unless other arrangements are made. I authorize all information to be released to get my bills paid. I authorize the Doctor to perform any services needed for my best care outcome, after he has answered all my questions. No information from my care here will be released to anyone without my written consent according to the HIPPA laws.

MEDICARE PATIENTS: Dr. Siegfried is NOT a participating provider with Medicare. Therefore, if the patient is of medicare age they will be asked to sign a Advance Benificiery Notice of Noncoverage (ABN FORM) and the patient is responsible for payment in full at time of service for treatment received.

CONSENT TREATMENT: Although Doctor will do his best to help me, I also understand that no cures are promised or implied and any risks regarding care at this office will be explained to me upon my request. I now authorize the Doctor to proceed with any necessary treatment after all my questions have been answered. I have read the clinic's office policies and consent to treat information, and I agree with them by signing below:

Name (Print): ______________________________

Signature: ______________________________

Date: ______________________________

Parent/Guardian's (required if patient is a minor):

Print: ______________________________

Signature: ______________________________

Date: ______________________________

Again, thank you kindly for taking your time to fill out these forms.
We look forward to helping you and earning your referrals!

Dedicated To Your Health and Wellness,

DR. Siegfried

Chiropractic Physician