

___ 1050 Northgate Drive Suite 350 San Rafael CA 415-526-3808

___ 65 Third St Suite 15 Point Reyes Station CA 415-663-9333

Today's Date _____

We welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

This is a Fee for Service office. We expect payment at the time of service unless other arrangements have previously been made.

Full Name: _____ **Date of Birth:** _____

Mailing Address: _____

City: _____ **State:** ____ **Zip:** _____

Home Tel	(___) ___ - ___	OK to leave a message?	Y N
Work Tel	(___) ___ - ___	OK to leave a message?	Y N
Cell Tel	(___) ___ - ___	OK to leave a message?	Y N Appt Reminders? Y N

Employment: FT___ PT___ Retired ___ Not Employed: ___ Occupation: _____
Please be specific in describing your work _____

Email Address: _____ OK to contact by email? Y N Appt Reminders? Y N

Insurance: _____ Please discuss with Dr.Borge. Complete separate form

Marital Status: Single Married Divorced Legally Separated Widowed Not Applicable

Emergency Contact Name: _____ Telephone _____
Relationship: _____

Briefly describe the reason for your visit _____

On a scale of zero to ten, with ten being the worst and zero being no pain, how would you rate your current pain? _1_ _2_ _3_ _4_ _5_ _6_ _7_ _8_ _9_ _10_ Circle one

Major Operations and/or Hospitalizations: *(Please list surgeries and/or hospitalization reasons and dates)*

Medical History & Conditions to advise the doctor of. Check all that apply.
Heart Disease _____ High Blood Pressure _____ Low Blood Pressure _____ Lungs _____
Kidney _____ Liver _____ Gall Bladder _____ Urinary Tract _____ Circulatory _____
Digestion _____ Neurological _____ Concussion _____
Others not listed: _____

Current Medications: (Please include any non-prescriptions as well such as aspirin, supplements etc.)

Medication Name	Dose	Frequency of Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

If you need more room, please list additional medications on back of page.

Allergies: (Please list any allergies you may have to medications and food)

Height: _____ **Weight:** _____ *Scale is in office*

Demographics Details Required for Electronic Health Records:

Race: _____

Ethnicity: _____

- Asian
- American Indian or Alaska National
- Black or African American
- Native Hawaiian
- Other Pacific Islander
- White
- Declined

- Hispanic or Latino
- Not Hispanic or Latino
- Declined

Smoking Status:

Please circle one/more

- Never Smoked
- Current Everyday Smoker: Qualify: Heavy Smoker Light Smoker
- Current Some Day Smoker
- Former Smoker

Patient Signature

Today's Date

If Patient is under 18 years of age, Name and Signature of Parent or Guardian Today's Date

Please review and sign Informed Consent form attached.

Thank you for taking the time to complete this information.

Informed Consent for Chiropractic Treatment of your Pain*

*This consent form complies with California Chiropractic Code of Regulations, Title 16, Division 4, Article 2, Section 319.1.

The nature of Chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may occasionally feel a slight click of the joints during the adjustment procedure. Chiropractic treatment also includes activity advice, exercise, hot or cold packs or electric stimulation. Your Chiropractor will recommend treatment she/he determines is most appropriate for your condition.

Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold and electrical stimulation.

Serious bodily harm is extremely rare and not an inherent risk of Chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, Chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves or spinal cord although these would be extremely unlikely with the non-force procedures used at this office. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or Chiropractic care. Your Chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. *Please inform your Chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture or previous severe injury.*

Other options for the treatment of pain include: *do nothing - live with it, over-the-counter medications, physical therapy, medical care, injections or surgery.* There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of Chiropractic treatment, and may use the space below for this purpose.

My signature below confirms that I have read the paragraphs above and that I understand what my Chiropractor has told me about possible risks of Chiropractic treatment and that I have had an opportunity to ask questions and have my questions answered. Also, I have fully disclosed to my Chiropractor my medical history regarding the above specified complicating factors and all other conditions that have caused me pain in the past.

Patient Name and Signature

Today's Date

Patient is under 18 years of age, Name and Signature of Parent or Guardian

Today's Date

Martin Borge, D.C.
Practicing Non-Force Chiropractic in Point Reyes Station and San Rafael CA

Form updated April 2013