BOURNE CHIROPRACTIC

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION Date: _____

Last Name : _____ First Name : _____ MI: _____

Street Address : _____ Apt : _____

City : _____ State : _____ Zip : _____

Email : _____

Home Phone : (_____) _____ - _____ Cell Phone : (_____) _____ - _____

Date of Birth : _____ Age : _____ Sex : ____M ____F Left Handed___ Right Handed ____

Marital Status : ___Single ___Married ___Divorced ___Widowed ___Minor ___Partnered for ___years

PATIENT CONDITION

Overall Health (circle one) Excellent / Good / Fair / Poor / Other : _____

Occupation : _____ Employer : _____

REASON FOR VISIT : _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ____ Yes ____ No ____ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) : _____

Type of pain: ____Sharp ____Dull ____Throbbing ____Numbness

____Aching ____Shooting ____Burning ____Tingling

____Cramps ____Stiffness ____Swelling ____Other

How often do you have this pain? _____

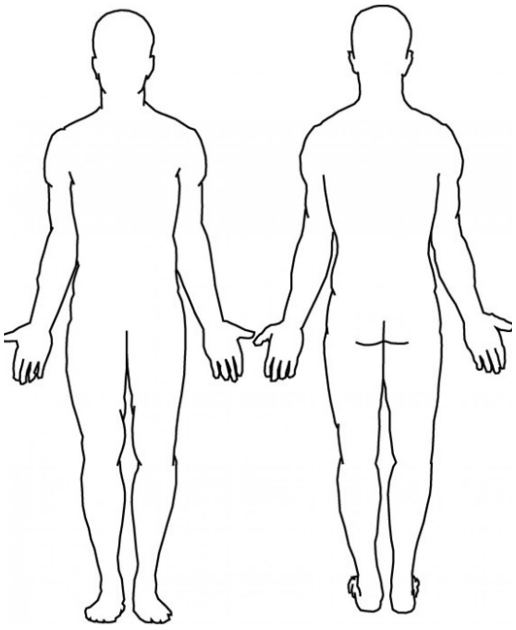
Is it constant or does it come and go? _____

Does it interfere with : ____Work ____Sleep

____Daily Routine ____Recreation

Activities or movements that are painful to perform:

___Sitting ___Standing ___Walking ___Bending ___Lying Down



IN CASE OF EMERGENCY, CONTACT:

Name : _____

Relationship : _____

Emergency Contact Phone : (_____) _____ - _____

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Are you currently under the care of a physician or other healthcare professional? ____Yes ____ No

If yes, please provide name and date of last visit: _____

Are you currently taking medications? ____Yes ____ No

List all current medications and supplements:

Medication	Reason	Medication	Reason	Medication	Reason

List all Vitamins, Supplements, Herbs, and Minerals currently taking:

Vitamins	Supplements	Herbs	Minerals

List any major illnesses (with approximate dates):

Illness	Date	Illness	Date

List any surgery or operations (with approximate dates):

Surgery	Reason	Date

List any allergies:

Allergy	Symptoms	Allergy	Symptoms

Do you?: ____Smoke ____ Drink Coffee ____Drink Alcohol Frequency? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

2004 Hounz Lane
Louisville, KY 40223

(502) 426-4511

Thank you for listening to the referral of someone close to you and choosing Bourne Chiropractic. This document is designed to help you understand the health choice you have made: Chiropractic, Homeostasis, and Health Optimization.

Chiropractic is the Philosophy, Art, and Science of addressing the misalignment of the joints of the Spine, Cranium, and Extremities. These misalignments are called Subluxations. A subluxation occurs in the human body from 4 causes:

1. Nutritional Imbalance
2. Environmental Toxins
3. Macro / Micro Physical Trauma
4. Mental Stress

Where there is a Subluxation in the body, there is tension of the Fascia or Connective Tissue and Physical Asymmetry results. This asymmetry will imbalance Energy Flow, impede or excite physiology, degenerate your posture, and strain the muscle systems that you move.

Homeostasis and Health Optimization is achieved when the doctor and patient team together and work to address the causes and the reduction of the Subluxation Complex. The Chiropractic platform of Sacro Occipital Technique (S.O.T) combined with a detailed review of your Health History, Physical Exam, a series of in depth looks at your Systems Physiology (The 7 pillars), are the vehicles that will be used. Chiropractic Care and the recommendations of Nutritional Supplements is how we plan to achieve your health and wellness goals.

_____ By initialing, I acknowledge that I have read and understand the health choice as explained above.

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PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF CHIROPRACTIC NUTRITION ANALYSIS

PLEASE READ BEFORE SIGNING

I specifically authorize Dr. Bourne to perform a Chiropractic Nutritional Analysis to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health and **not for the treatment or "cure" of any disease.**

I understand the Chiropractic Nutritional Analysis is a safe, noninvasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies are imbalances in these areas could cause or contribute to various health problems.

I understand that Chiropractic Nutritional Analysis is not a method for "diagnosing" or "treating" of any disease, including conditions of cancer, AIDS, infections, or other medical conditions, but rather, I understand that Chiropractic Nutritional Analysis is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Signed: _____

(If minor, signature of Parent or Guardian is required)

Witness: _____

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CONSENT TO CHIROPRACTIC SERVICES AT BOURNE CHIROPRACTIC

I authorize the performance of diagnostic and therapeutic procedures, whether or not arising from unforeseen conditions that the clinician may consider necessary or advisable in the course of my health care. I understand there are fees for these services, and I will be charged accordingly. I also understand that payment for these services is due at the time services are rendered. These charges will be explained to me at my request. The nature and purpose of the procedures, possible alternatives, risks involved, possible consequences, and the possibility of complications have been explained, or will be explained at a time necessary by the doctor.

_____ _____

Patient Signature Date

_____ _____

Witness Date

If signing for someone other than yourself, please indicate below their name and your relationship to them.

Patient Name: _____

Your Relationship to Patient: _____

BOURNE CHIROPRACTIC

Patient Information and Consent for Dry Needling as a Procedure for the Assessment and Treatment of Myofascial Trigger Points and Tender Points

Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculoskeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating, and monitoring changes in myofascial trigger/tender points. During this procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles may be used, and the procedure may be performed during more than one office visit. The number of needles and the frequency of the procedure will depend entirely on your condition at each office visit. There is little to no pain with this procedure. There is little to no bleeding with this procedure. While an infection is an unlikely event with this procedure, whenever there is penetration of the skin, there is the risk of infection. Other unlikely but possible events include fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin, or acetaminophen (for example Tylenol, Advil, Aleve, or Bufferin), please inform the doctor **by circling "Yes" or "No" next to each question**.

YES NO I have a fear of needles.

YES NO I have a genetic bleeding disorder.
Please specify: _____

YES NO I have a history of a blood disorder that can be transmitted to another person.
Please specify: _____

YES NO I am regularly taking blood thinning (anti-coagulation) medication.
Please specify: _____

YES NO I am regularly taking pain relievers.
Please specify: _____

I have read this Patient Information and Consent carefully, ***I understand this procedure is not acupuncture*** and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me. I give permission to have the treated region(s) photographed and/or videoed for records/educational purposes.

Patient Name (Please print): _____

Signature: _____ Date: _____

If patient is less than 18 years of age parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this document

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date