WEBER
CHIROPRACTIC

Weber Chiropractic LLC
Tina Caputo LAc LMT

Thank you for choosing Weber Chiropractic LLC. Integrative health care is enhanced dramatically when we are able to gather a full picture of a person's health history from the past to current day. Please take your time working through this form. It would be preferred that it is received 1 day prior to your visit for us to have a more effective visit with you. Thank you!

New Patient Paperwork

Full Name:______________________________________ **Date:**_____
Address:____
City/State/ Zip____
Best number to reach you? _______________________(H)(W)(C)
Email:____
Birthdate__________________ **Sex at birth**____ **Pronouns**_________
Occupation____
How did you hear about us? __________________________________
Emergency Contact ____
Phone ____________________________ **Relation** ________________
Name of Primary Care Physician: _____________________________

Health Concerns

Please list your most important physical, emotional, or mental health concerns. Indicate which are most immediate and important to you.

1.____
2.____
3.____

How do you rate your overall health? Excellent Good Fair Poor

Please mark (x) for all current conditions and (P) for all past conditions:

__Anxiety
__Asthma/Lung conditions
__Arthritis/tendonitis
__Auto Immune Condition
__Blood Clots
__Bone Condition
__Cancer
__Chronic Pain
__Circulatory/ Heart
__Depression
__ Diabetes Type __
__Digestive problems
__Disc Problems
__Edema Swelling
__Fatigue
__Fibromyalgia
__Genitourinary conditions
__Head aches/ Migraines
__Hearing problems
__Hernia
__ High Blood pressure
__ Jaw pain (TMJ)
__Joint Pain/stiffness
__Low Blood Pressure
__Lymphatic Condition
__Numbness and tingling
__Reproductive health
__Sinus problems
__Sleep difficulties
__Varicose Veins
__Vision Problems

Please explain any condition that you have marked above.

____

____

____

____

Are you pregnant? If so, how far along are you? ______________

____

Number of: Pregnancy__ Births __ Miscarriages __ Abortions__

Please list any significant illness, diseases, injury or surgical interventions you have experienced and the approximate date you were diagnosed.

____

____

____

____

Please list any prescribed medication, vitamins, herbs and others you are taking and their dosages. (Attach extra page if needed)

____

____

____

____

Please list any food, medication, or environmental allergies and your reaction to them.

____

____

____

____

Please list any significant family medical history. For example: Cancer, diabetes, high blood pressure, thyroid disease, auto immune.

____

____

____

____

Nutrition:

Do you follow any specific diet? If yes, please specify:

____

____

Primary foods in your diet:

____

____

List the excluded foods:____

____

Caffeinated drinks per day:___

Alcohol Drinks per day :_____

Tobacco use per day: _______

Exercise:

Hours spent in physical activity per week: ______________________

Types of exercise: ____

____

Hobbies: ____

Anything else that you feel your acupuncturist should be aware of:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Informed Consent:

The treatment and therapies rendered or recommended by Weber Chiropractic LLC providers may be different from those usually offered by a medical doctor or another licensed health care provider. As a patient, I have the right to be informed about my health condition and recommended treatment. I have had the opportunity to discuss the potential benefits, risk and hazards involved as well as other treatment options available to me. I have authorized medical and health care treatment for myself or my minor by the practitioners at Weber Chiropractic LLC (Christina Caputo LAc LMT)

I, ____________________________________, do herby give my consent to services rendered and provided to me or the patient named below as a patient of Weber Chiropractic LLC. I understand

that the patient care is directed by a licensed healthcare provider and I consent to these services rendered and provided to me by these professionals

I understand that missed or canceled appointments without 24 hours of notice prior to the scheduled visit will result in a cancellation/ no show fee of $60 per missed visit.

I have fully read and understand the above agreements and authorizations.

To attest to my consent, I hereby affix my signature to this authorization for treatment.

Patients name (Print) ______________________________ DOB _____

Patient's signature _________________________________ Date _____

Consent to Treatment of a Minor Child

I, ____, being the parent/legal guardian/ personal representative of ____________________________________ have read and fully understand the above informed consent and hereby grant permission for
my child to receive treatment at Weber Chiropractic LLC.

Guardian/ Representative Signature ___________________________