FAMILY CHIROPRACTIC ASSOCIATES

PATIENT INFORMATION

PLEASE PRINT – THANK YOU!

First Name: _____ Middle Initial: _____ Last Name: _____

Address _____City, State, Zip _____

Primary Phone ( ) _____ Home Phone ( ) _____ Cell Phone ( ) _____

Would you prefer text reminders for follow up appointments? □ Yes □ No

Date of Birth_____ □ Male □ Female Social Security Number: _____

Marital Status: □ M □ S □ W □ D Names of Children: _____Is patient a student: □Y □ N

Spouse's Name: _____ Spouse's Date of Birth: _____Spouse's SSN: _____

Emergency Contact: _____Home Phone ( ) _____Cell Phone ( ) _____

EMPLOYMENT INFORMATION:

Patient's Employer: _____Work Phone ( ) _____Ext:_____

FINANCIAL RESPONSIBILITY:

I have read and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I agree that Family Chiropractic Associates will prepare any necessary reports and forms to assist me in collecting from my insurance company. Any amount authorized to be paid directly to Family Chiropractic Associates will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I end or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By signing below you acknowledge your financial responsibility as stated above.

CONSENT FOR PHYSICIAN TO PROCEED WITH TREATMENT:

I understand that if I am accepted as a patient by physicians of Family Chiropractic Associates, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

By signing below you acknowledge your consent to proceed with treatment.

HIPPA PRIVACY PRACTICE NOTICE:

- Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History.
- Under the privacy rule, may be required by State Law to grant greater access or maintain greater restrictions provided under federal law.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health History that is maintains.
- Will distribute any revised Privacy Notice to you prior to implementation.
- Will not retaliate against you for filing a complaint

By signing my name below I acknowledge that I have received or was offered a copy of the Privacy Practices Notice from Family Chiropractic Associates.

To enable us to share information with specific family members or friends, please list below those individuals with whom your protected health information can be shared.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please note that if injuries are due to a Worker's Compensation Claim then only that information will be released to your employer.

PATIENT NAME (*PRINT*):_____Today's Date: _____

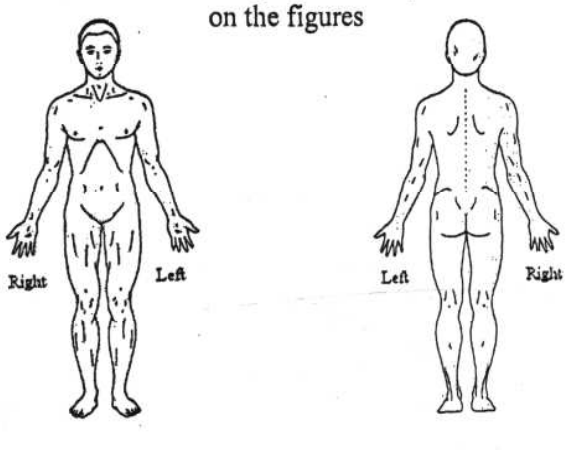
Signature: _____

Name of Personal Representative: _____Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient: □ Parent □ Guardian □ Power of Attorney

Family Chiropractic Associates

Please mark your areas of pain on the figures



Name: _____

Chief Complaint: _____

Today's Date: _____

1. When did it start? (Date) _____
2. Did it begin suddenly or gradually? _____
3. Did anything cause the onset? YES NO
   If so, what? _____
4. Have you ever had anything like this before? _____
5. Does it radiate to another part of your body? YES NO
   If so, where? _____
6. Describe the sensation: (Circle all that applies)
   Dull, sharp, stabbing, burning, aching, shooting, numbness, tingling or other: _____
7. Rate the intensity 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 (0= NO pain 10=worse pain)
8. Has your condition: ____ Improved _____ Worsened _____ Same
9. Have you found anything that makes it better? YES NO
   (rest, ice, heat) _____
10. Does anything seem to make it worse? YES NO
    (activities, coughing, morning, night) _____
11. Has there been any changes in your bodily functions? YES NO
    (Urination, respiration, digestion, bowel, vision)
12. Has your condition affected daily activities? YES NO
    If so, in what way? _____
13. Have you tried any store bought or home remedies? YES NO
    If so, what? _____
14. Have you sought any other professional care for this? YES NO
    If so, whom and what procedures were performed _____
    Family Physician? _____ Previous Chiropractor? _____
15. Have you had any XRAY / MRI's to the afftected area(s)? YES NO
    If so, where / when? _____
16. Do you have any other symptoms or problems? YES NO
    If so, what? _____

Medical History

Have **you** ever had any of the following medical conditions / diseases?

- ☐ Alcohol / Drug Abuse
- ☐ Allergies (Specify) _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (Specify) _____
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Fainting / Seizures / Epilepsy
- ☐ Frequent Neck Pain
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Kidney Problems
- ☐ Lower Back Pain
- ☐ Heart Attack
- ☐ Heart Defect (Congenital)
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valves
- ☐ Heart Surgery / Pacemaker
- ☐ Heart Murmur
- ☐ High / Low Blood Pressure (Circle one)
- ☐ Severe / Frequent Headaches
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid (Hypo / Hyper)
- ☐ Tuberculosis
- ☐ Ulcers / Colitis

Family History

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart problems / Stroke
- ☐ High / Low Blood Pressure (Circle one)

List all previous surgeries and bone fractures with dates:

Date: _____Procedure: _____ Date: _____ Procedure: _____

Date: _____Procedure: _____ Date: _____ Procedure: _____

Please list any other serious medical conditions or diseases you currently have or have ever had: _____

_____

Are you taking **ANY** prescription medications?

- ☐ Blood thinners
- ☐ Vitamins
- ☐ Muscle relaxers
- ☐ Over the Counter
- ☐ Nerve pills
- ☐ Pain killers

Please list all medications *including <u>dosages and what condition it is prescribed for</u>*:

Medication: _____ Dose: _____ For? _____ Medication: _____ Dose: _____ For? _____

Medication: _____ Dose: _____ For? _____ Medication: _____ Dose: _____ For? _____

Medication: _____ Dose: _____ For? _____ Medication: _____ Dose: _____ For? _____

Please list any medications you are allergic to: _____

Please select one: ☐ I have never smoked ☐ Former smoker ☐ Current smoker, how much: _____pack / day

Family Physician _____ Date of last office visit_____

Previous Chiropractor(s) _____

List other Specialist(s) consulted and treatment given

Name _____Treatment _____

Name _____Treatment _____

Name _____Treatment _____