

WELCOME TO FAMILY FIRST CHIROPRACTIC

858-9355

Name:		Today's Date:	
What You Prefer to be Called:			
Mailing Address:		City:	Zip:
Home Phone:	Work Phone:	Cell:	
Email Address (for newsletter and appointment information):			
Birth Date:	Age:	Social Security #:	
How did you learn about our office?			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Spouse's Name:			
Name and Ages of Children:			
Name of Insurance Company and Id #:			
Occupation:			
Recent Work-Related Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Recent Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Chiropractic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Last Visit Date:	

Please check reasons for pursuing chiropractic care:

___ I'm continuing ongoing care from another chiropractor.

___ I'm interested in wellness and natural health care.

___ I have a specific condition or conditions that concerns me.

Primary Reason: _____

Secondary Reason: _____

Other factors contributing to the primary and secondary reasons: _____

Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other_____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

Past Health History:

A. Previous illnesses you've had in your life:

B. Previous injury or trauma:

Have you ever broken any bones? Which? _____

C. Allergies

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E: Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F: Females/Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period?

Social and Occupational History:**A. Level of Education:**

high school some college college graduate post graduate studies

B. Job description:

C. Work schedule:

D. Recreational activities:

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

Family Health History:

Check the following conditions that YOU have had. Circle conditions that are common to FAMILY MEMBERS.

- AIDS Alcoholism Cancer Diabetes Epilepsy Hyper/Hypothyroidism
 Heart Disease Lung Disease Scoliosis Stroke Ulcers Multiple Sclerosis

Deaths in immediate family:

Cause of parents or siblings death

Age at death

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In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

- Headaches/Migraines Asthma Sleep Problems Menstrual Problems Weight Problems
 Postural Imbalance Gas/Bloating Dizziness/Fainting Ringing in Ears Allergy/Sinus Problems
 Bladder Trouble Ear Infection Frequent Colds Arthritis Intestinal Problems
 High Blood Pressure Fatigue Short leg/Orthotics Menopausal Symptoms

The Stress Test:

The following areas of stress can cause mis-aligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Physical/Emotional/Chemical Stress:

- | | |
|--|--|
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Slips/Falls |
| <input type="checkbox"/> Car Accidents | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Work Injuries | <input type="checkbox"/> Sitting on a Wallet |
| <input type="checkbox"/> Sleeping on Stomach | <input type="checkbox"/> Extensive Computer Work |
| <input type="checkbox"/> Carrying Heavy Purse/Backpack/Child | <input type="checkbox"/> Repetitive Lifting/Bending |
| <input type="checkbox"/> Driving for Many Hours | <input type="checkbox"/> Continuous Hours Sitting/Standing |
| <input type="checkbox"/> Children Stress | <input type="checkbox"/> Career Stress |
| <input type="checkbox"/> Relationship Stress | <input type="checkbox"/> Concealed Feelings |
| <input type="checkbox"/> Quick Tempered | <input type="checkbox"/> Smoker/Second Hand Smoke |
| <input type="checkbox"/> Poor Diet/Excessive Sugar | <input type="checkbox"/> Caffeine |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Prescription Drugs |
| <input type="checkbox"/> Over-the-Counter Drugs (ex. Tylenol/Motrin) | |

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Please provide a signature for any of the following that apply to you.

Consent to evaluation and adjustment of a minor child

I _____ being the parent or legal guardian of _____
 (print name of consenting adult) (print name of minor)

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

 Consenting Adult's Signature

 Date

Pregnancy Release (Females of Child-Bearing Age)

I certify that to the best of my knowledge I am not pregnant, and Dr's Chae and Monya Tracy and their associates have my permission to perform an x-ray evaluation. I have been advised that x-rays could be hazardous to an unborn child.

 Signature

 Date

Functional Rating Index

For use with neck and/or back problems only. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity

0- No Pain Pain	1- Mild Pain	2- Moderate Pain	3- Severe Pain	4- Worst Possible Pain
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2. Sleeping

0- Perfect Sleep Disturbed Sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally
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3. Personal Care (washing, dressing, etc.)

0- No Pain No Restrictions	1- Mild Pain; No Restrictions	2- Moderate Pain; Go Slowly	3- Moderate Pain; Some Assistance	4- Severe Pain; 100% Assistance
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4. Travel (driving, etc.)

0- No Pain on Long Trips	1- Mild Pain on Long Trips	2- Moderate Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips
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5. Work

0- Usual Work + Extra	1- Usual Work, No Extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work
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6. Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities
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7. Frequency of Pain

0- No Pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)
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8. Lifting

0- No Pain with with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain Any Weight
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9. Walking

0- No Pain with after Any Distance	1- Increased Pain after 1 Mile	2- Increased Pain after ½ Mile	3- Increased Pain after ¼ Mile	4- Increased Pain Any Distance
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10. Standing

0- No Pain with after Any Time	1- Increased Pain after Several Hours	2- Increased Pain after 1 Hour	3- Increased Pain after ½ Hour	4- Increased Pain Any Time
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Total _____ (/4, X10) = Functional Rating Score _____%

Patient or Guardian Signature _____

Date _____

Treating Doctor Signature _____

Date _____

Family First Chiropractic
800 Hwy 290 West Bldg. C Suite 100
Dripping Springs, Texas 78620
512-858-9355

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (PHI) will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk. This office reserves the right to modify the Privacy Practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment, or health care operations. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my Personal Health Information (PHI) in accordance with the Privacy Practices.

I, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier or other healthcare professionals. I do understand that PHI will be used **within** the office for purposes of my care, to those individuals designated by the doctor.

Patient or Parent Signature: X _____ Date: _____

Assignment of Benefits / Assignment of Cause of Action / Contractual Lien

Our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. In the event that your insurance company does not pay in a timely manner, you may be asked to contact your insurance carrier.

If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment of Rights and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owed by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed to assist in the prosecution of such claims for benefits upon request.

To any insurance company providing benefits or settlement of a claim, you are instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds to pay the total dollar amount of all sums which I owe on account to the above named doctor and treating facility within 30 days following your receipt of medical bills submitted by the doctor and/or treating facility.

I instruct checks to be made payable to Family First Chiropractic, and payment to be sent to 800Hwy 290 West Bldg. C Suite 100 Dripping Springs, Texas 78620.

This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as are determined to be owed, due and payable on my account and remit payment of all such sums directly to the above named doctor and/or treating facility upon receipt of my settlement award(s).

Patient or Parent Signature: X _____ Date: _____

Informed Consent for Treatment

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare".

• I, the undersigned parent or legal guardian of _____ (minor child), hereby give my permission to the staff of Family First Chiropractic to treat said child.

I hereby acknowledge that if I do not keep appointments as recommended to me by my treating doctor, he/she has complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. I understand that failure to complete my recommended treatment plan may jeopardize my case.

Patient or Parent Signature: X _____ Date: _____