

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

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

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:

EFFECT:

Bathing/Washing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration (Reading)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Patient signature: _____ Today's Date: ___/___/___

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information 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 Protected Health Information 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 Protected Health Information. 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 or her Protected Health Information 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 Protected Health Information. 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 health information in accordance with it.

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

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

At the beginning of your treatment 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. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, 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 and Conveyance of Lien Interest

I hereby execute and provide **Irrevocable Lien Interest and Assignment of Proceeds** to apply to all monetary proceeds from any third party liability insurance policy and/or all monetary proceeds from any PIP/medical payment insurance policy to which I am entitled, and from which I am to be paid in the form of an insurance settlement(s), claim(s), judgment(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled, or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above named doctor and/or treating facility. 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 to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: _____ Date: _____

INFORMED CONSENT TO 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".

Patient Signature: _____ Date: _____