Family Chiropractic CLINIC

DR. JEFF HAND
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Doctors of Chiropractic

Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance details.
Please note that this is confidential

Today's Date _____

Are you here today by referral and by whom _____

Have you ever been to chiropractic before □ Yes □ No When was your last visit _____

_____

Last Name First Name Middle Name

_____

Address Date of Birth (MM/DD/YY)

_____

City State Zip Code Home Phone Cell Phone

Ethnicity: □ Hispanic □ non-Hispanic □ refuse **Language Spoken**: □ English □ Other_____

Marital Status: □ Single □ Divorced □ Widow □ Separated □ Married

Race: □ White □ African American □Hispanic □ American Indian □ Asian □ More than one race □ refused

Email Address _____**Spouses Name**_____

Emergency Contact_____**Phone** _____

Your Occupation_____

Your Employers Name_____**Work Phone**_____
May we contact you at work? □ Yes □ No

Employer Contact_____

Primary Care Providers Name and Clinic Location_____

Insurance Carrier_____**Policy number**_____

Insured's First and Last Name _____ **Policy Carrier** □ Self □ Spouse □ Parent

NAME _____

The symptom(s) that have prompted me to seek care today include:_____

_____

How did your symptoms start? _____

_____

When did you first notice your current symptom? _____

Intensity (how extreme are your current symptoms? (please circle one)

Absent 0 1 2 3 4 5 6 7 8 9 10 Agonizing

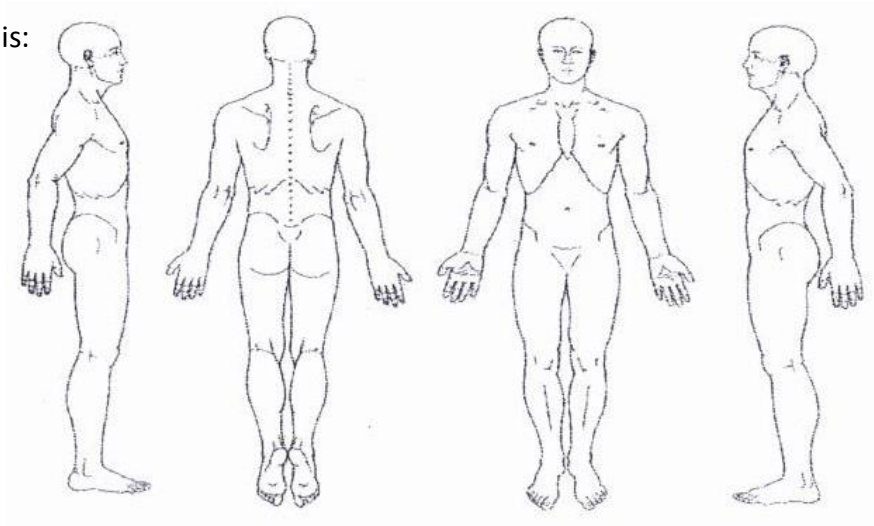
Duration and Timing (When did it start and how often do you feel it?

☐ Constant ☐ Comes and goes How Often? _____

Does the pain radiate shoot or travel and where?_____

Please show where your pain is:

□ Numbness
□ Tingling
□ Stiffness
□ Aching
□ Cramps
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other



What makes the pain worse_____Better? _____

Previous treatments

□ Prescription medications	□ Surgery	□ Ice	□ Other _____
□ Over the counter medicine	□ Acupuncture	□ Heat	
□ Physical Therapy	□ Chiropractic	□ Massage	

What else should the doctor at Family Chiropractic know about your condition? _____

_____

Please list ALL current medications and supplements _____

_____

Are you currently pregnant? □ Yes □ No Due date? _____ Number live births _____

NAME _____

Family History

Relative	Previous/current major Illnesses (heart, cancer, diabetes)
Mother	_____
Father	_____
Sibling 1	_____
Sibling 2	_____

Are there any other hereditary health issues that you know about? _____

_____

Social history

Alcohol use	□ Daily	□ Weekly	□ How much _____
Coffee use	□ Daily	□ Weekly	□ How many cups daily _____
Tobacco use	□ Daily	□ Weekly	□ How many packs a day_____
Exercise	□ Daily	□ Weekly	□ How many times weekly_____
Pain reliever	□ Daily	□ Weekly	□ How much_____
Soft drinks	□ Daily	□ Weekly	□ How many daily_____
Water intake	□ Daily	□ Weekly	□ How much daily_____
Recreational Drugs	□ Daily	□ Weekly	□ How much weekly_____

Activities of Daily Living – How does your condition interfere with life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting					Grocery Shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering/bathing				
Bending over					Dressing				
Climbing Stairs					Rolling in bed				
Using a computer					Getting to sleep				
Getting in/out of a car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				

Previous surgical procedures and dates_____

_____

Previous Imaging and date

□ MRI _____ □ X-rays_____ □ CT Scan_____ □ Other_____

NAME _____

	Past	Current		Past	Current		Past	Current
Headache			Migraines			Diabetes		
Neck Pain			Heart Attack			Excessive thirst		
Upper Back			Chest Pain			Frequent Urination		
Mid Back			Stroke			Allergies		
Lower Back			Kidney Stones			Depression		
Shoulder pain			Kidney Disorder			Lupus		
Elbow pain			Painful Urination			MS		
Wrist pain			Bladder infection			Epilepsy		
Hand pain			Loss of Bladder control			Dermatitis/rash		
Hip/Upper leg pain			Prostate Problems			HIV/AIDS		
Jaw pain			Stomach Pain			Birth Control		
Arthritis			Ulcer			Hormone replacement		
Rheumatoid arthritis			Asthma			Cancer		
Fatigue			Chronic sinus			Visual disturbances		
			High blood pressure			Dizziness		

Informed consent

I hereby consent to chiropractic adjustments and procedures: including various therapy modalities that are necessary with the adjustment by the chiropractic doctor or anyone working in this clinic authorized by the doctor. I will also have an opportunity to discuss with the doctor and/or with the office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. By any standard, I understand that chiropractic treatment is conservative and very safe. I also understand that, as in all health care, and in the practice of chiropractic, there are some very slight risks to treatment including but not limited to: muscle strain/sprain, rib fracture, disc injuries, and vertebral artery injury (i.e. stroke). I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure and future procedures, which the doctor feels at the time based on facts then known, is in my best interest. I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all of my present and future chiropractic care.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account; 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 suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable

□ **I have been offered and would *like* a copy of the Financial Information and Privacy policy of this clinic.**
□ **I have been offered and *decline* a copy of the Financial Information and Privacy policy of this clinic.**

_____

If the patient is a minor child, or needs a guardian signature, please print their full name:

Signature:_____ Date (MM/DD/YYYY)_____