Chiropractic Intake & History

Family First Chiropractic Wellness Center

Patient Information

Patient Name _____
Address_____
City: _____ State:_____ Zip:_____
Home Phone: _____
Cell Phone: _____
Email: _____
Sex: ☐ M ☐ F Age: _____ Birthday: _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered
Have you been to a chiropractor before? _____
When was your last visit?_____

Employer/School _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Spouse's Occupation _____
IN CASE OF EMERGENCY, PLEASE CONTACT:
Name _____
Relationship _____
Contact Number _____
Who may we thank for referring you?_____

How Can We Help You?

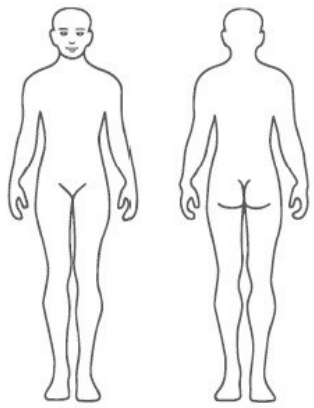
What brings you in today? _____

If you are already experiencing a symptom, how long have you been living with it?_____

How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas to the right where you are experiencing symptoms.



What does it feel like? (Check where appropriate).

☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Cramping
☐ Swelling ☐ Stabbing
☐ Nagging ☐ Other: _____

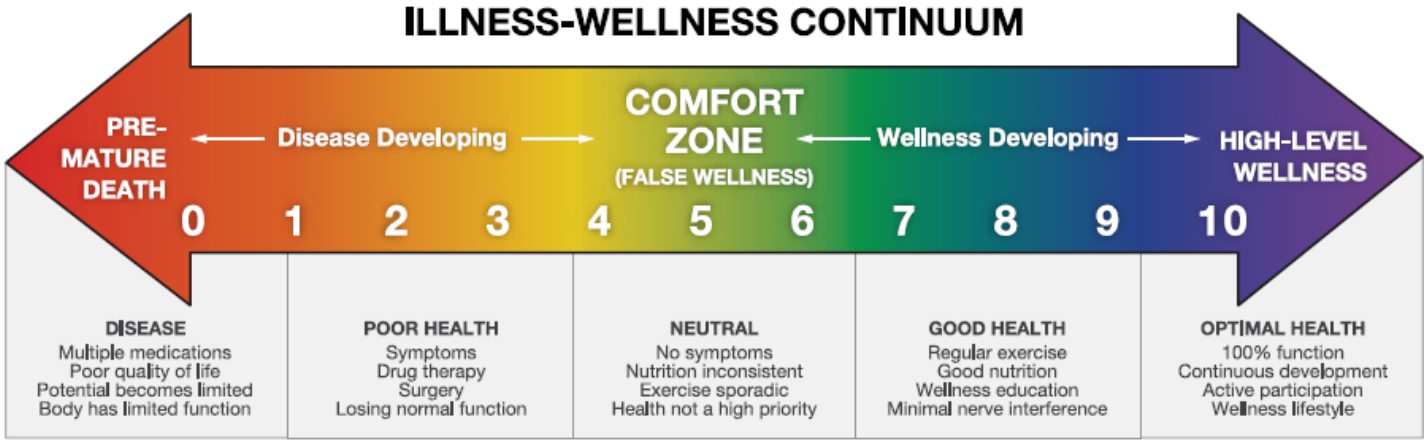
Impact of Your Symptoms

How is this symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	❑	❑	❑	❑	Energy	❑	❑	❑	❑
Exercise	❑	❑	❑	❑	Attitude	❑	❑	❑	❑
Recreation	❑	❑	❑	❑	Patience	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Productivity	❑	❑	❑	❑
Sleep	❑	❑	❑	❑	Creativity	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑	Other _____	❑	❑	❑	❑

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10
0 = NOT COMMITTED — 10 = VERY COMMITTED

Patient Wellness Assessment



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

Immediate: _____

Short Term:_____

Long Term: _____

Children & Pregnancy

How many children do you have? _____

Children's ages? _____

Children's health concerns? _____

Stressors during pregnancy? _____

Are you currently pregnant? ☐No ☐ Yes, I am Due: _____

Number of past pregnancies: _____

Health concerns regarding this pregnancy: _____

Interventions during delivery: _____

Health & Illness History

☐ AIDS/HIV
☐ Alcoholism
☐ Anxiety
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma/Allergies
☐ Back Pain
☐ Cardiovascular Issues
☐ Cancer
Type:_____
☐ Circulation Issues
☐ Childhood Illness
☐ Depression
☐ Diabetes
☐ Digestive Issues
(Constipation, Diarrhea, GERD, IBS)
☐ Elbow/Wrist/Hand Issues
☐ Endocrine Issues (Thyroid)
☐ Foot/Ankle Issues
☐ Sleep Issues
☐ Headache/Migraines
☐ Heart Disease
☐ Hepatitis
☐ Hip Issues
☐ Immune Issues
☐ Lymphatic Issues
☐ Multiple Sclerosis
☐ Neck Pain
☐ Reproductive Issues
(Irregular Cycles, Cramps, Infertility, PMS, PCOS, ED)
☐ Ringing in Ears
☐ Scoliosis
☐ Shoulder Issues
☐ Stroke
☐ TMJ Issues
☐ Urinary Issues
☐ Osteoporosis
☐ Other _____
_____

Allergies, Medications, & Supplements

Allergies: _____

_____

Medications: _____

_____

Supplements:_____

_____

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Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

Family First Chiropractic Wellness Center

Photo and Video Permission

Family First Chiropractic Wellness Center takes pictures and videos for clinical and training purposes. I give Family First Chiropractic Wellness Center permission to take additional photos and videos of me that may be used in office promotion, fliers, social networks, such as Facebook, Instagram or Twitter and/or the website www.ffcwc.com.

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

What FFCWC is all about...

Our Vision: It is our vision that every man, woman, and child be checked regularly for subluxation throughout their lives.

Our Mission: It is our mission to educate and adjust as many families as possible toward optimal expression of life, utilizing the principles and paradigm of chiropractic and empower you to take control of your health.

Our Purpose: To provide the best opportunity for members of our community to live long, healthy, happy lives from their first breath to the last so they can fully engage in life and provide value to their families and community.

Our Premise: Families that are in our office are more equipped to handle the stress of everyday life.

Our Core Values:

Passion: We have a passion for service, life, and chiropractic.

Professionalism: We exhibit the skill, judgement, and behavior that is expected from a person who is trained to do a job well.

Teamwork: Our team works together by combining each of our unique strengths to create an environment that allows us to provide outstanding value to our community in a very simple and efficient way.

Love: Our service to our community is rooted by an unselfish and compassionate concern for the good of each individual we care for.

Authenticity: Each member of our team behaves in a manner that allows them to stay true to one's own personality, spirit, and character.

Integrity: We adhere to a code of having high moral values when serving and communicating the chiropractic paradigm to the world.

Simplicity: We act efficiently and communicate in a way that is easy to understand. We are experts at simplifying the complex.